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ABSTRACT

The conference was the first conference at a national level to deal solely with American Indian health needs. Representatives of 31 Indian health boards and 49 states gathered together to learn more about and discuss some of the most vital issues facing the delivery of health services to Native Americans today. In an important attempt to understand and gain input into National Health Insurance before the issue becomes a finality in this country, participants listened to an explanation of current proposed National Health Insurance legislation. They also heard a proposed Indian position on the subject, a composite of the different positions submitted over the previous year by tribes and health boards to a core group under sponsorship of the National Indian Health Board (NIHB). Panel discussions dealt with the National Health Planning and Resource Development Act and its health board applications in various parts of the country, the Indian Self Determination Act and its implications, the Indian Health Care Improvement Act, and tribal and urban health board development and management. An overriding concern voiced during workshop sessions was the need felt by non-reservation Indians for representation on NIHB and conference participants later decided as a body to ask NIHB to research the possibility of an off-reservation member. This paper presents an abbreviated transcript of the conference, the resolutions passed by the participants, and the resolutions referred to the National Health Insurance Core group. (Author/NQ)

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The First National Indian/Alaska Native Health Conference, held June 29-July 1, 1976 in Palm Springs, California was the first conference at a national level to deal solely with Indian health needs. At the request and through the support of the National Indian Health Board (NIHB), representatives of 31 Indian health boards and 49 states gathered together to learn more about and discuss some of the most vital issues facing the delivery of health services to Native Americans today.

In an important attempt to understand and gain input into National Health Insurance before the issue becomes a finality in this country, conference participants listened to an explanation of current proposed National Health Insurance legislation. They also heard a proposed Indian position on the subject, a composite of the different positions submitted over the previous year by tribes and health boards to a core group under NIHB sponsorship.

Panel discussion at the conference dealt with, among other concerns, P.L. 93-641, the Health Planning Resource and Development Act, and its health board applications in various parts of the country; P.L. 93-638, the Indian Self Determination Act and its implications; S522, later to become the Indian Health Care Improvement Act; and tribal and urban health board development and management.

An overriding concern voiced during workshop sessions was the need felt by non-reservation Indians for representation on NIHB and conference participants later decided as a body to ask NIHB to research the possibility of an off-reservation member.

It is hoped that the conference served, as well as proving informative to participants regarding current legislation affecting Indian health, to provide an opportunity for exchange of ideas and methods for dealing with the problems faced by Indian health boards, reservation and urban alike, and to open lines of communication between such health boards and other concerned individuals throughout the country, and between those groups and persons and NIHB.

A second National Native/Alaska Native Health Conference is now being planned for the fall of 1977.

(This report has been prepared by Janis Herman Dukepoo, Sandra Wolf Nichols and L. Joy Bossert. Its publication was made possible through Contract No. HSA-241-76-0204 with the Department of Health, Education and Welfare, Health Services Administration.)

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The National Indian Health Board, Inc., (NIHB) was incorporated in the State of Colorado on December 21, 1972.

NIHB was organized to serve as an advocate for tribal groups and organizations, specifically dealing with health on state and federal levels, and to inform and increase awareness among organizations of legislation affecting Indian people.

Composed of 12 members, the Board of Directors, represents all geographically defined regional Indian Health Service areas, with representatives selected by their area health boards.

The premise to which NIHB is committed and to which all its activities are directed is that "health care services delivered to Indian Americans and Alaska Natives should be of the highest quality and of sufficient quantity so that Indian Americans and Alaska Natives attain an equal or better health condition than other American citizens."

As a means of achieving the stated goals and objectives, NIHB is organized to "evaluate those programs and services provided by the Indian Health Service to insure that it is functioning according to stated policy or congressional intent to improve the health conditions of the Indian American and Alaska Native."

Thus, the basic thrust of NIHB activities has been interest in developing projects related to Indian health programs.

As an organization concerned with Indian health issues, NIHB possesses a high degree of special cultural sensitivity and knowledge of Indian health programs and policies.

NIHB board members at the time of the Palm Springs conference included: Joe Benitez, California Rural Indian Health Board; Howard Tommie, United Southeastern Tribes; Ada White, Billings; Lorna Patricio, Tucson; Dennis Tiepelman, Alaska; George Platero, Albuquerque; Perry Sundust, Phoenix; Walter Woods, Aberdeen; Donald LaPointe, Bemidji Sub-Area; Chief Tanyan, Oklahoma; Mel Sampson, Portland; and Elwood Saganey, Navajo.

Current members of the board are: Harold Janis, Aberdeen; Ethel Gonzales, Alaska; George Platero, Albuquerque; Donald LaPointe, Bemidji; Ada White, Billings; Timm Williams, California; Elwood Saganey, Navajo; James Cox, Oklahoma; Perry Sundust, Phoenix; Mel Sampson, Portland; Irene Wallace, Tucson; and Howard E. Tommie, USET.

NATIONAL INDIAN HEALTH BOARD, INC.

NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Riviera Hotel
Palm Springs, California (714) 327-8311
June 29, 30, July 1, 1976

- Agenda -

"Improving Health for Improving Life"

Monday, June 28, 1976

2:00 pm -
9:00 pm Registration $20.00

Tuesday, June 29, 1976

Registration $20.00
Master of Ceremonies-Joe Benitez NIHB, Conference Coordinator
9:00 am Invocation - Chief Edwin Tanyan, NIHB
Flag Song
Presentation of Colors - 29 Palms Marine Corps Color Guard
9:15 am Welcoming Address-Howard E. Tommie Chairman, NIHB
9:30 am Priscilla Pete, Tribal Council Secretary, Agua Caliente Tribe
9:35 am Representative for Mayor of Palm Springs
9:45 am Conference Mechanics-Joe Benitez
10:00 am Coffee Break
10:30 am Keynote Speaker
Buffalo Tiger, Chief of Miscosukee Tribe of Florida
11:15 am Keynote Speaker
Dr. Emery A. Johnson, Director Indian Health Service, Rockville, Maryland
12:00 pm Lunch
1:30 pm Mistress of Ceremonies - Lorna Patricio, NIHB
National Health Insurance
Introduction and Summary of Activities - Elouise DeGroat, Tribal Affairs Officer, Navajo Area Indian Health Service
2:50 pm Break
3:00 pm Small Group Discussions
Consensus Issues
Unresolved Issues
Legislative Strategy
Urban Indian Concerns with NHI
5:00 pm Interim NHI Group
7:00 pm American Indian School of Medicine
9:00 pm Dr. Taylor McKenzie, Executive Director, Navajo Health Authority and Dean, American Indian School of Medicine
7:00 pm-
9:00 pm Alcoholism Workshops

Wednesday, June 30, 1976

9:00 am Mistress of Ceremonies - Lillie McGarvey, NIHB
9:15 am Irene Wallace - P.L. 641 Chairwoman, Papago Executive Health Staff
10:00 am Coffee Break
10:15 am Dr. Taylor McKenzie - S.2525 Director, Navajo Health Authority
11:00 am Erin Forrest - P.L. 638 National Tribal Chairman's Assn.
12:00 pm Lunch
Master of Ceremonies - Mel Sampson NIHB
Tribal and Urban Health Board Management Moderator - Ada White, NIHB
5:00 pm Panel: Charles Stitt, D.D.S.
Area Director
Portland Area IHS
Luana Reyes
Executive Director,
Seattle Indian
Health Board
Joe Benitez
CRIHB
Howard Tommie
NIHB
Lillie McGarvey
Alaska
Gordon Belcourt
Director, Health
Services Board
Blackfeet Tribe
Small Group Discussions - Go to designated room
7:30 pm Steak-fry
Entertainment

Thursday, July 1, 1976

8:00 am National Health Insurance Presentation of Position from Interim Group - Sandra Nichols, NIHB
Consensus
Vote
9:30 am -
10:00 am Tribal & Urban Health Board Management Summary - Ada White, NIHB
10:00 am Resolutions Committee - Lillie McGarvey
11:00 am Conference Evaluation - Hilda Lorandi, NIHB
11:15 am -
11:45 am Wendell Chino, Chairman of Mescalero Apache Tribe
"The Future of Indian Health"
11:45 am -
12:00 pm Conference Wrap-up - Joe Benitez, NIHB
1:30 pm -
5:00 pm Joint NIHB and all Indian Health Boards Joint Session - Howard Tommie, NIHB Chairman

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NIHB CHAIRMAN Howard Tommie.

Dear Friends:

The achievements of the National Indian Health Board, now in its fifth year, are symbolized in these proceedings. Participation in the 1st National Indian-Alaska Native Health Conference held in Palm Springs, California on June 29-July 1, 1976, included 31 Indian Health Boards and individuals from 49 states. This meeting was a beginning of strength and unity for Indian professionals and lay people in the health professions serving Native Americans.

The success of the 1st National Indian-Alaska Native Health Conference would not have been possible without support from the NIHB Board and other key persons from the organization. It is impossible to name all of the people who helped to pull the program together, but let me point out just a few. I especially want to thank Joe Benitez, Conference Coordinator, for his many months of hard work on the Conference. Also, thanks to Dr. Emery Johnson, Director of Indian Health Service and his staff for their participation and to our keynote speaker Wendell Chino, President, National Tribal Chairmen's Association, my special thanks.

I believe that you will find the proceedings useful to you in your work. I expect that this Conference is the beginning of growth and achievements for the improvement of Indian health through the programs and activities of many agencies.

Sincerely,

Howard E. Tommie
Chairman, '76-'77

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United Indian Health Service, Inc.
Tsurai Health Center
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Trinidad, California 95570

JOE BENITEZ, California Rural Indian Health Board representative to NIHB and conference coordinator.

Dear Conference Participant:

It was my pleasure to serve as conference coordinator for the 1st National Indian/ Alaska Native Health Conference. The conference brought together Indian people representing many tribes, and these tribes have one common goal: the improvement of Indian health. This conference was the first national conference to cover only Indian health issues. I believe this is a symbol of a future in which Indian people will work together to provide the best in health delivery system.

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The National Indian Health Board was able to bring together the most knowledgable and experienced individuals in the health field to provide up-to-date information to the conference participants. During the small group sessions individuals were able to articulate their frustrations, concerns and were also able to come away with a common base of understanding between many different health groups.

I would especially like to thank all the NIHB members and staff who worked so diligently to make this conference a success. I would also like to thank Dr. Emery Johnson and his IHS staff for their support.

Ray Patencio, Agua-Caliente tribal chairman, and other tribal members provided an excellent dinner and entertainment.

I especially appreciate the efforts of the C.R.I.H.B. staff whose hard work made the conference run so smoothly. And all the

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participants who attended, that made the conference a success.

Thank You,

Joe Benitez,
Conference Coordinator

REGISTRATION time.

PARTICIPANTS from some 31 health boards, 48 tribes and 49 states attended NIHB's First Indian/Alaska Native Health Conference.

PROCEEDINGS OF THE
1st NATIONAL INDIAN/ALASKA NATIVE
HEALTH CONFERENCE
(Abbreviated Transcript)

OPENING SESSION
June 29, 1976

The 1st National Indian/Alaska Native Health Conference was called to order by Joe Benitez, Conference Coordinator, at 9:30 a.m. Mr. Benitez introduced himself and the honored speakers on the dais: Howard Tommie, National Indian Health Board Chairman; Chief Tanyan, Chairman of the Seminole Tribe of Oklahoma; Ralph Thornton from Palm Springs Convention Bureau and Ray Patencio, Tribal Chairman of the Agua Caliente Tribe of Palm Springs. Chief Tanyan gave the invocation and the 29 Palm Springs Corps Color Guard members made the presentation of the colors. Mr. Benitez introduced the Indian singers and Howard E. Tommie, National Indian Health Board Chairman, and Chairman of the Seminole Tribe of Florida.

Howard Tommie: I would like to introduce the members of the National Indian Health Board. There is one board member from each Indian Health Service Area and each area selects its own board member. From the Phoenix area we have Perry Sundust; Billings: Ada White; Oklahoma: Chief Tanyan; Albuquerque: George Platero; Tucson: Lorna Patricio; Aberdeen: Walter Woods; Portland: Mel Sampson; Alaska: Dennis Tiepelman; California Rural Indian Health Board: Joe Benitez; Bemidji: Donald LaPointe; and Elwood Saganey: Navajo.

One of the things that the National Indian Health Board hopes to accomplish is to make tribes and Indian people familiar with the health management programs, and all the services that are available in the health field, especially the Indian Health Service. Of course, there are a number of services available from areas other than Indian Health Service, which Indian people have capitalized on. They include states, counties, and regions which have services, funds and personnel that deal with health. Health is the priority of the National Indian Health Board. We, as Indian people, search for better facilities and for better health personnel to take care of our health needs.

The National Indian Health Board listens to Indians across the country to find out what their particular health problems are. Of course, the National Indian Health Board cannot remedy all the health problems that Indians have, but we can sort out the available resources for your

particular problems and advise the Indian Health Service. The National Indian Health Board can also inform the Indian community on Federal health policies and legislation. And this is, mostly, what we have been doing. As long as I have been a tribal representative, this is the only conference that I have attended which deals strictly with health issues. The National Indian Health Board is proud to have you here. We hope the conference will be beneficial to you all.

Joe Benitez: Thank you very much. As I stated earlier, Buffalo Tiger, who is scheduled to speak will not be here today. But we do have Jonathon Ed Taylor from United Southeastern Tribes.

John Ed Taylor, (Eastern Band of Cherokees): What we want to talk about here, is Indian leaders, and tribal health providers. What can the Indian people do for their own health? I know we sit there on the reservations a long time just waiting for things to happen. It's easy for us to blame Indian Health Service if we don't get a lot of the things that we need and want. If you want a hospital built on your reservation, just writing a proposal is not going to get it. You've got to do some lobbying. There are a lot of things on Indian reservations that we're learning nowadays. For example, the Community Health Representative program, I think, is one of the best things that Indian Health Service ever put on the reservations. The Community Health Representative program finds out our peoples' needs.

I think there are a lot of things that Indian people have done, themselves, that Indian Health Service does more from the Washington level. A lot of times, I have come before the National Indian Health Board with resolutions for support for the reservations, and every time I have come, the health board has been more than willing to support us. Also, we went to different tribes and asked tribes on a local level to write resolutions asking Congress to try to provide money so we could have hospitals on our reservations. Right now, if we had the money that these presidential candidates are spending on their campaigns, we could build a medical school on every reservation in the country.

There are a lot of people operating clinics coming up here today that our delegation from Cherokee is wanting to hear. We can learn from the people in the audience and, also, the people on the National Indian Health Board. Our tribes support the National Indian Health Board. Let's take one or two times a year, such as this gathering, that we can get together and everybody work in accord. This is all we need.

Dr. Emery A. Johnson, M.D., Assistant Surgeon General; Director, Indian Health Service: Here we have a good many Indian people together, all focused on the issue of health care for their people. It is a first at the national level. I hope it's the beginning of a number of activities over the years, in which the Indian people can develop a common voice, a common direction for their governments and Indian health.

This is a historic year. We all hear that it's the Bicentennial. You've heard a great bit about that. There are a few of us who recall that this is also an important anniversary. This is the 100th anniversary of the Battle of the Little Bighorn. The Sioux, Crow and some of the rest of us know what that signifies. Recently, the National Congress of

American Indians had their annual celebration of that anniversary and honored two very fine Indian people: Forrest Gerard, from the Senate Interior Committee and Franklin Ducheneaux, from the House Indian Affairs and Public Lands Subcommittee, who has done a tremendous job in the last several years developing Indian legislation. I think that initiative and that kind of recognition is the sort of thing that we hope to gain from a conference like this and can be brought home to your communities, to the other tribal leaders, so that the next hundred years of this nation's history will be a much happier and more fruitful century for Indian people.

The Declaration of Independence has as the rights of all Americans: life, liberty and the pursuit of happiness. I believe central to that whole issue is health. In the absence of health, obviously, there can be no life. If you're tied by illness, a wheelchair or through a bed, you cannot have real liberty and certainly illness does not promote happiness. I think that health is a way of life. It's something that is with us and part of us every day. We now describe, in the national sense or international sense, the definition of health as mental, physical and social well-being, not just the absence of disease. That's supposedly a very profound definition of health in various languages. When you look into traditional beliefs on health, health is one of mental, physical and social well-being and has always been. Harmony with the environment, harmony with one's fellow members of the tribe and harmony with the entire universe. This has been the concept of health for Indian cultures.

I know, and it has only been in recent years, the rest of this country has begun to understand the significance of some of the Indian beliefs and the truths in so many of the Indian beliefs. If we're going to deal with health, and that's what we're talking about in this conference, improving health and improving life, we've got to look at where we've been and where we are. What do we have to do next? Perhaps we could spend a few moments looking at what we've done, and where we are going. Tomorrow, I will have completed 21 years, 21 years in the Indian Health Program. Now, you'll all say I don't look old enough to have been around for 21 years.

My wife and I went to a little reservation up in northern Minnesota. We've had things to see and be a part of with the changes that have taken place throughtout Indian country. Twenty-one years ago, it was said with truth, that the health status of Indian people was lowest of any group in the United States, and we can prove that by any health statistical measure that anyone has ever devised. There was no question. In 1955 and 1956, they did an Indian health survey at the request of Congress. There were nine reservations in the country where an in-depth study was done, and we had the opportunity to participate in that through the Baseline study of Indian health. O.K., where have we been? You know, as well as I do, the changes that have taken place. The reductions in Indian mortality, the reductions in maternal mortality and the reductions in diarrheal disease, even tuberculosis. Maternal mortality is at the upper level lower than that in the general population. Life expectancy has been increasing. We have facilities and resources that we wouldn't have even dreamed of 21 years ago. We now have almost 1,100 different locations throughout Indian country where health services are provided. That is to say nothing of the services provided by the tribal health workers.

Well, we've still got a lot of work to do. We've got to look at problems. Again, as we look around at some of the issues on the program, we're beginning to focus on the kinds of problems that are not easily handled. We can, in fact, deal with pneumonia. We can treat and arrest tuberculosis. Now we're dealing with the tremendous wasting of Indian life and Indian happiness created by accidents. There isn't an immunization against accidents. There isn't a magic penicillin shot to cure accidents. We are looking at the problems of alcoholism and the problems of mental health.

This concern, today, rests with the elders on the reservation without whom we would not have reservations. Without them, there would not be a reservation or Indian culture. We have the problem of maintaining well-being for the elderly. They are not the traditional kinds of things that doctors, nurses, dentists and engineers deal with. We're talking about the kinds of things that require community acts. These are community issues. Well, let's take a look at some of the basic principles. As I said earlier, we start with the basic assumption and principle that health is a way of life. Health is not medical care. The involvement of the people, involvement of the community is fundamental in improving the health status.

We took the position that involvement of the community begins by responding to health needs. But, what was the primary health need 21 years ago? I don't know what it was like on your reservation, but I know what it was like on mine. The needs that we saw, the needs that the Indian community saw were the needs for acute medical care. The mothers wanted their babies to live when they brought them to the hospital. And we started providing acute medical care.

We began to share with each other the concerns for prevention, for community change, the kinds of behaviors the community could undertake to improve their own health. We got to the point where preventative services and community services became a felt need. We started out with basic medical care and worked together into a program of balance between acute medical care and preventative care in community services. We went on from there, and everything leads up to one major turning point in Indian health. We look at the development of the Community Health Representative program as the catalyst that really moved things off dead center. We moved from there to the development of tribal health boards, tribal health authorities and tribal health departments. Now, many Indian tribes are delivering important parts of their health services.

As you can see, the direction has been one of consistency, evolution, moving toward that ultimate goal of the community with its own health program. There are a number of things that we have to have. If there are neighbors polluting your water supply and you can't deal with that alone, then that's a community problem. There are things that the individual can do for himself and some things that require the participation of others. If we look at the Indian community, the health of the Indian community, we find the same kind of issues. We can, in fact, compare the health of a community to the health of an individual. For example, the Pueblo people can promote their health through such things as planning, developing an Indian staff, developing programs and activities for their hospital or clinic. Our goal is to deal with local tribal councils and local health boards. We're talking about

national policies, national legislation, the development of resources on a national basis. No matter how unique your individual problems may be, there are some over-riding national issues that you need to pay attention to, and unless you, as Indian people, develop a voice and present that voice, you're not going to be heard.

We're living in a tentative society. Indians are a minority. They are a minority out of 210 or 250 million people. How are we going to succeed in getting the legislative policy to protect the resources and to obtain what we need in this kind of a competitive society when we are such a small number?

Well, there are a few things that have to be done. Mr. Ed Taylor gave a capsule summary of some of the things that have to be done. We can use the resources that are available and I could go through this audience and name tribe after tribe that understands this and does very well on an individual basis. First of all, we have got to have the facts and information. You can't ever influence and administration or the Congress unless you know what you are talking about. You've got to have the ability to take these facts and design a reasonable approach to deal with the problems. Call it planning. It also requires training in order to be able to get the facts to carry out the plans. It requires trained people. We can't operate complex health delivery systems or effective programs unless people are trained and know what they are doing. When we have trained people, we can have good results. Thank you.

Tuesday, June 29, 1976
National Health Insurance

Lorna Patricio (M. Ceremonies): I am Lorna Patricio, a representative of the National Indian Health Board from the Tucson area, and to my right is Ellouise De Groat. She is Tribal Affairs Officer for the Navajo Area Indian Health Service. We also have with us Lillie McGarvey from Alaska. She is a member of the Task Force on Health of the American Indian Policy Review Commission. To my left is Dan Press, attorney in Washington, consultant to the National Indian Health Board on National Health Insurance and Stanley Tenorio, who is from the Albuquerque Service Unit Indian Health Board.

Before we get into the subject of National Health Insurance, we would like to take a few minutes to find out from conference participants what you would like to see come out of the Indian Health Task Force, and to let you know some of the things that the Task Force still needs from the Indian community. I will now turn the meeting over to Mrs. McGarvey.

Lillie McGarvey: I asked to speak to this conference about the American Indian Policy Review Commission, especially Task Force #6 on Indian health. The Task Force on Indian Health Care is gathering data on the needs of Indian health and how we can improve our health.

For those of you who may not know what the commission is all about, I think before I begin, I will give you some background information. The American Indian Policy Review Commission was created by passage of

Public Law 93-580 on January 6, 1975. The Congress of the United States had recognized thatthe relationship between the government and the American Indians had deteriorated because government policy for Indians had been reversed several thimes. It took into consideration the fact that the last time these relationships had been reviewed was after 1928. The American Indian Policy Review Commission proposed that congressmen and Native Americans, appointed by Congress, should study the relationship between the Federal Government and American Indians. Recommendations of the commission will be submitted for congressional action. Final recommendations are to be made to the Congress by January of 1977.

Through this commission, American Indians and Alaskan Natives, for the first time, have direct access to Congress in recommending legislation for Indians and also in recommendation for policy and procedural changes in federal agencies, so that they might meet the needs of our people. As an individual, a tribe, or an organization concerned with Native American affairs, you can contribute in these ways: By submitting your own reports for records in the commission report to Congress; working with one or more of the task forces in development of their reports; testifying at commission or task force hearings held in your area; answer any questionnaires or surveys promptly...

Lorna Patricio: One of the things that we will be going into is the activities that led up to National Health Insurance. I'll be going into that and Ellouise De Groat will be making a summary as to where we are at present with NHI. Stan Tenorio will follow through with the Congressional testimony that he participated in, and Dan Press will be covering unresolved issues. After we're finished with that, we will be breaking into seven groups.

One of the things that happened with the Papago Tribe is that we started looking at National Health Insurance legislation. As some of you may know who attended that meeting in Tucson last year, often, when legislation comes through, a lot of the Indian tribes may not pick it up right away. After the bill passes and becomes a law, it's harder to make any changes. If this particular legislation should pass without any Indian input, Indians will be in trouble. At the Tucson conference, position papers were arrived at. Indian tribes were then to return to their own areas, and start discussing it with their people, and the National Indian Health Board made a commitment that they would follow through with a future workshop, or a future conference to bring back those Indian groups so that we could develop a unified position, which we could go back to Washington with. Now, I'll turn it over to Ellouise to give you an overview as to where the NHI effort is at this time.

Ellouise De Groat: Thank you very much. I would like, particularly, to speak today on introduction and summary of activities of the National Health Insurance. I think it would be interesting to the audience to know that today there are, in the audience, 84 tribes from every state in our country with the exception of Hawaii, and I think it's interesting to know, also, there are 35 health boards represented in this conference. I think, to me, this really indicates a lot of interest at this conference. All of us are aware that in the past, the American Indian people have been given few, if any, opportunities to be involved. Today marks one occasion on which we as American Indian people, can have

impact on federal legislation. Many times, the Indian people have not been involved, and I think the Indian people are beginning to come together as a total group of people who can support one another on Indianism instead of Tribalism.

It is interesting to know, also, that the idea of the National Health Insurance Legislation has been around since 1947, but, yet, we as Indian people did not know anything about National Health Insurance until a year ago. The National Health Insurance got serious attention in 1970 when 30 bills were introduced to Congress, but yet, I daresay there are tribal government officials that had no idea what National Health Insurance was. But yet, such a legislation can be so meaningful to the Indian people. National Health Insurance legislation did not get off the ground because of the 30 bills introduced to Congress. Each had a different approach as to how National Health Insurance should be implemented.

The National Health Insurance is going to be one of the biggest Federal Health Programs since the Social Security Act of 1930. It is so big, and so very important that it will have a major impact on health programs for all people in the United States, but even more so, for us as Indian people. The National Health Insurance could have a good, or a bad impact on Indian health programs. A good impact will depend on each of us Indian people, by speaking out and supporting each other on one unified position. If we do not make our voices known, someone else could make these very important decisions for us, which could damage our health boards and systems that we now have. Again, I would like to emphasize that such health bills have been around since 1947, but until a year ago the Indian people had no knowledge of National Health Insurance. I think all of us as Indian people are indebted to the Papago tribe for having the foresight, and taking the lead in informing and warning the Indian people of possible benefits and dangers in having the National Health Insurance.

I think many people in the audience are still wondering what this is all about, and even our own tribal leaders still don't have a position on National Health Insurance. Why is it so important for us here? Those of us who were at the Tucson conference got first-hand information on the National Health Insurance, and throughout the year, many of the tribes discussed and analyzed the content of National Health Insurance. There were some position papers that were developed. The Navajo reservation had a three day conference on National Health Insurance, and also, representatives of the New Mexico Inter-Tribal Health Board testified on Indians and National Health Insurance for the House of Representative's Committee of Ways and Means. At this time, I would like to have Stan Tenorio give some highlights of that congressional hearing.

Stanley Tenorio: Thank you. It is an honor to have this opportunity to tell you about my visit to Washington, and my testimony. First of all, I can start with giving the Papago tribe credit for bringing this whole matter to our attention. The Santa Fe Service Unit Indian Health Board was present at the Tucson meeting and learned that National Health Insurance issues were a major concern. Immediately, the health board went into several planning sessions, and decided to follow up on those particular NHI issues. We decided that it was appropriate to act at that time. We felt it was appropriate that we put together a position to present to the Congress.

The highlight of our testimony in Congress on December 2, 1975, was that the Congress of the United States, before this testimony, was not aware of the kind of impact that the National Health Insurance would have on our programs, because the National Health Insurance Program did not address itself, or in any part include, the Indian. The Congress was quite receptive and responsive to our presentation...

Congress was really concerned. I think they will try to listen to us, at least this is what I was assured of. They will be willing to work with us, and help us in any way to make sure that there are provisions made in the health legislation to protect those concerned. Thank you.

Lorna Patricio: Thank you, Stan. I think all of these different conferences in the Indian community gave opportunities for the Indian people to begin to develop a consensus position on National Health Insurance. The purpose of today's conference is to begin to do this. In the meantime, the national Indian organizations, including Indian Health Service, have been sitting on the sidelines, waiting for the Indian position on National Health Insurance. I think that the Indian Health Service, and the other national Indian organizations, should be commended for this, because they are not speaking for the Indian people any longer, unless it comes from the grass roots. The Indian Health Service has been very supportive in terms of waiting to see what the Indian people come up with. There is still some very important work that needs to be done, not only among the Indian communities, but in Congress, and it is very important that, today, we as Indian people, can come together and make our positions known. I would like to turn the mike over to Dan Press, who will elaborate more on these different NHI bills.

Dan Press: Thank you, Lorna. As Ellouise mentioned, out of the various local meetings and conferences held over the past year, tentative consensus positions have been developed, tentative Indian positions on National Health Insurance. In a few moments Stan Tenorio is going to review the tentative consensus position that has been developed, and just to provide some background for those of you who have not been to a conference on National Health Insurance, I'm briefly going to discuss some of the different National Insurance bills. It's not really an in-depth discussion, it's just merely a brief review to make the presentation clearer.

"Proposed National Health Insurance Legislation"

As Ellouise mentioned, there were approximately 30 different bills on National Health Insurance in Congress. Every congressman has his own idea on how the National Health Insurance should be influenced. I want to review the three major kinds of bills very briefly.

One is the Kennedy bill, introduced by Senator Ted Kennedy. This is the most comprehensive kind of National Health Insurance bill, sometimes called the "cradle to grave" bill. It covers all Americans,

everyone is treated as one class, there is no distinction, the poor people, rich people, working people, and non-working people are treated the same. Everybody is entitled to coverage under it. It covers a broad range of health services for almost any kind of health services you need, go to a doctor, get that service, and National Health Service Program will pay for it. It would be financed through an income tax, and a payroll tax. Payroll tax would be about 1% of your weekly payroll. I would be administered by the Federal Government. They would set up a new agency in Washington to administer it. So that is the broadest kind of bill. It does not set up hospitals, it does not hire doctors. All it does is pay for services. But this would pay for a very broad range of services and would pay for everybody in the United States.

At the opposite enod of the spectrum is a bill called the Catastrophic Bill. They call it a "Castastrophic Bill" because when you've had a health catastrophy, the health insurance will come and bail you out, and it will only help you after you have spent approximately $9,000 per year out of your own pocket on health care. So, really it doesn't mean too much to most people. Very few of us will ever be able to spend $9,000. So, that's the other extreme, as compared to the Kennedy bill. The Catastrophic Bill says "We'll only bail you out before you sink."

Then, in between, there are numbers of other bills and, perhaps, the most popular, the kind of bill that the administration has been pushing and that congressmen have been pushing. Right now we have a number of different ways of paying for people's health care. A lot of people have health insurance through their employer. Either you pay part of it or the employer pays all of it. Then, when you get sick and go to a doctor the bills are billed to Blue Cross, Blue Shield, Aetna, and so on. The second method for paying for health care is Medicaid. Medicaid takes care of all of the poor people. The third kind is Medicare, that takes care of the old people. So what the Ullman Bill and the Administration Bill say is "We already ahve the basis for a system, let's just tighten it up." So, one thing it would do would be to require all employers to offer health insurance. Right now, it's voluntary. If this bill were passed, all employers would have to offer health insurance. Employers would have to pay 75% of the cost, employees the rest. Now, Stanley Tenorio will give a summary of the draft NHI position that we have developed.

"Proposed Conference NHI Draft Position"

Stanley Tenorio: The draft proposed Indian position contains the following principles, Principle number 1: It is the consensus Indian position that the existing Indian Health Service-tribal-urban Indian health system should remain as the mechanism for financing and delivering health services to Indians, and so such, Indians should be exempted from participation in the NHI program. NHI must not be used as a total or partial substitute for, or supplement to, the direct financing of health services from Congress, through IHS, to Indian people. The IHS tribal system is the Indians' own system. It is the clear manifestation of the federal government's

legal, historical, and moral commitment to Indians in the area of health. In a sense, the Indians' national health program. It is also the vehicle for achieving the federal government's objectives of self-determination for Indians. This system needs to be strengthened, but this should be done directly rather than fractionalizing the Indian health system by assigning responsibility for financing it to NHI.

Principle number 2: The rights and benefits that will be made available to all citizens through NHI must, also, be made available to Indians. IHS and tribal programs must be eligible for reimbursement from NHI when they provide covered services to eligible Indians. Because IHS is underfunded, we expect that NHI should provide adequate funding resources within the framework of IHS and tribal health programs. Indians must receive full rights to the guaranteed programs and must be reimbursed by NHI for the actual cost of each provided covered service. A rationale for that principle is that the Indian Health Service is presently severely underfunded. It is estimated by IHS that they are able to provide less than 70% of the Indians' immediate needs for basic health services. At 70% of the need, only 70 of the 100 Indians requiring otitis-media operations can get their operations. The other 30 must wait until next year's funding comes in. In contrast under NHI, each eligible person, who needed such an operation, would get it. The financing would be guaranteed by NHI. Therefore, IHS and tribal programs must be followed to receive reimbursement from NHI. The reimbursement they do receive must be used to fill the severe gap in services and not simply to replace existing resources.

Principle number 3: Indian tribal governments must be recognized as the appropriate governmental authorities for administration of NHI on their reservations. NHI must not give state governments authority or jurisdiction over Indians or Indian health programs. This is an issue that all of the Indian health groups did quite a considerable amount of work on because of the jurisdictional question. It is the consensus in the position that NHI give Indian tribal governments the sole authority for collecting payments, planning for health programs, and handling health funds and resources into their reservations, and that state government be given no such authority to carry out governmental functions on Indian reservations. The rationale of this principle is that it is important for tribal governments to administer their own programs such as some of them are doing at present.

Principle number 4: The principles of Indian self-determination must be incorporated into NHI legislation. The rationale for that is that the federal government has formally adopted the policy of self-determination for Indian tribes as established by the Indian Self-Determination Act of 1975. Indian tribes, not the federal government, are to make determinations regarding the needs and priorities of their tribal members. The federal government will respect those determinations and will assist tribes and development of capabilities to implement tribal goals and objectives. The principles must be incorporated into an NHI program and so far as NHI affects health care to Indians in the following manner: The Self-Determination Act gives the tribes the option of taking over BIA and IHS programs, and running them as tribal programs. The act and regulations, specifically, state that the federal government will not require tribes to take over federal programs. It is a function of the tribe to do so. NHI must not be used to compel tribes to assume responsibility for IHS health programs at a phase different, or faster, than

determined by the tribe. The tribes should have the right to decide how they will participate, or how they will manage each program.

Principle number 5: NHI must not diminish the Indians' legal, historical and moral rights to health care from the federal government at no cost to the Indian consumer. It is the consensus Indian position that there must be no compulsory taxes or premiums imposed on the Indian people by NHI. IHS must be empowered to pay whatever premium, co-payments and other charges that will be involved in using the benefits made available by NHI. Indians must, also, have the option of choosing not to participate in any NHI programs and to continue to use the free health care provided by IHS. Rationale for this principle is that federal health services to Indians were established pursuant to treaty obligations and consideration for the Indian land that was confiscated by the federal government. Indians have paid for their health services many times over; an infringement on land, water, and natural resources. The basic element of this special relationship between the federal government and the Indians of health is that Indians receive care from IHS at no cost to them.

Principle number 6: The rights of Indians living in non-reservation areas must be recognized and their rights to service protected by NHI. While Indians living in urban areas are entitled to benefits from NHI. NHI should not become an excuse to eradicate the rights of urban Indians through the special rights afforded to all Indians. NHI must recognize the Indian rights of urban Indians, and must provide mechanisms, so the NHI benefits will go to urban Indians in a manner which preserves their special Indian rights. And, that's the extent of my presentation.

Emmett Sarracino: I'm Emmett Sarracino, originally from Laguna, New Mexico. I now live in Los Angeles in the urban area...

The thing is, that our language should not read totally one sided but for all Indians. Right at the last there, it says the urban Indians should have their rights preservaed because of treaties. A lot of us have worked hard in the urban areas to have health programs, but nowhere does it really emphasize the fact that these should be continued. So, I think coordinated language should be used, not tribally, or not this or that, but Indians as a whole, so that there will be no conflict when this becomes, or comes before the Congress. Because when this gets to the legislation, this could really be picked apart.

Stanley Tenorio: Thank you. This issue will be taken care of by the small group sessions that will deal with the position of the urban Indian.

"Unresolved NHI Issues"

Dan Press: Stanley has presented what is a summary or composite of the different positions that tribes and health boards submitted to NIHB over the last year. It's still a tentative position and subject to change. However, in the positions that were submitted over the past year, there

were two areas where there was not agreement, and they still need to be resolved if they can be. They're relatively controversial.

Principle number 2 said that the benefits from NHI should be available to Indians. I don't think anybody disagrees with that. The question is, how should Indians tap that pot of money?

There are at least three alternatives: One, is that NHI can take over full responsibility for funding the basic in- and out-patient services that Indian Health Service delivers. Right now, IHS gets a line item from Congress every year that pays for the clinics and the hospitals. That's one option. Splitting up the money, it's not that different from what's going on now in some ways. Some of the mental health and alcoholism money comes from other agencies, and is filtered through IHS. The problem with it, is that it does split up IHS funding, and that could possibly lead to an erosion of Indian Health Service. On the other hand, NHI would have a lot more money for basic in- and out-patient services that IHS has now.

The second possibility is for IHS to bill National Health Insurance for each service provided to the covered Indians. That would be pretty much what they will be doing on the Medicare, Medicaid, and the Indian Health Care Improvement Act. So, what it means is that NHI would just be a supplement. You might not ever increase the amount of funding, the total funding that Indian Health Service gets.

The first approach separates the funding, so there is no overlay, and OMB can't cut the IHS budgets. The second approach says to just merge the whole thing into one big pot. The third way is to say, we don't want anything to do with NHI, we'll continue to try and get money for Indian Health Service, the way we have now, which is through the direct appropriation costs, lobbying, appropriations and going in and fighting for money. The advantage of that is that it doesn't provide any threats of dismemberment to Indian Health Service. The problem with it is you haven't gotten a lot of money that way. The Indian Health Care Improvement Act will help to some degree.

There are three different wasy Indians can get some of the NHI money into Indian Health Service. Each one has its benefits, each one has its problems. In the small groups on unresolved issues, we will be going over those and trying to decide on one, if possible. There is no clear cut answer.

The second unresolved issue has to do with taxes, or payment. Principal number 5 says that Indians should not be required to pay for health care; that the Indian rights to free health care were obtained when the Indians gave their land or resources or water to federal government. If you asked why they're funding Indian Health Service, I doubt if they would say that Indians have a right to free health service from the government because we took their land. I doubt if they would look upon it as a legal right.

O.K., what about taxes? The Indian position as Stanley stated is that we should not be charged for National Health Insurance. However, Congress sees National Health Insurance as a participatory program. They expect people to pay for it. To some degree, if you pay the taxes, you have a good chance of getting the full benefits out of NHI, increased

funding of Indian Health Service. If you don't pay the taxes, there is a good chance that none of the benefits from NHI will come to Indians. Are you willing to pay some taxes and increase benefits, or is the principle on free health care so important, that you're willing to stay with your own system?

It gets more complicated, however, because there are different approaches to National Health Insurance programs, some of which Indians probably couldn't be exempted from, even if they wanted to. For example, some bills say the NHI should be funded through income tax. There isn't going to be a separate item on your income tax form that says 'money for National Health Insurance'. There is no way that Indians could ever be exempted from that payment.

Second method of financing is payroll tax, where they'll take away 1% of your weekly payroll and use it for NHI. The third way of paying for NHI is through premiums and deductibles. Under most plans, poor people would not have to pay any of those things. So, 60% of the Indian population would be covered for free. That leaves 40% of the Indian population that earns over ¢6,000.

One of the things that the position has to do is reflect each one of these things. The benefits, and the taxes, are two unresolved issues that really come together. If you don't pay the taxes, then you're left in one of two positions: you're arguing that IHS should pay the taxes for Indians, and that's going to be hard to persuade Congress by saying that IHS should buy health insurance for all Indians. It's possible, but it's going to be very difficult to win. The other thing, if you say we don't want to pay taxes, you can continue with the present system.

In summary, in the small group sessions on unresolved issues, these two very related subjects need to be discussed. There needs to be some consensus reached on them and it's going to be a very tough decision because both issues are critical.

Tuesday, June 29, 1976
Small Group Sessions
(Conference participants met in numerous small group sessions to further discuss the National Health Insurance issue, following which the chairperson of each group made a report to the overall NHI Core Group. Following is the transcript of one of those sessions.)

Lorna Patricio, Chairwoman
National Health Insurance

Gaylord Fox: I am Gaylord Fox of the Social Security Administration here in Palm Springs. We're assigned to go over enclosure #2 with the heading of "Tentative Indian Positions on National Health Insurance". It is a draft of six principles compiled by the NIHB. National Health Insurance must recognize Indian Health Service and tribal health programs as major financiers and deliverers of health services to Indians. This is the position that has been taken by the group that has been studying it for the

past year. Our primary objective is to get your suggestions on these principles. Any suggestions?

Lorna Patricio: One of the things that particular principle is talking about is in regard to health services for Indians, and I think there have been several Indian tribes that have stated that they would rather that Indian Health Service continue to serve the Indians.

Unidentified speaker: Well, the way you described the Kennedy program, it sounded like a pretty good deal. The first significant proposals were not made until 1975. The first one was by Congressman Ullman from Oregon, and that was done in January 1975, and then we had the one by Senator Kennedy, and Representative Corman. That was, also, done in 1975, in March. And, we had another proposal by Richard Fulton in 1975. All of these are proposals of National Health Insurance. Basically, they are all proposing National Health Insurance in some form or another.

Gaylord Fox: Well, the latest I've heard is that NHI will not become a reality in less than two years, but what we're trying to do is put our foot in the door and get an established position on behalf of the Indians, so we'll have voice in how it finally turns out. Without the input, we can't make any modifications. Principle #1 is saying that IHS will still be the principal supplier of services. It's not going to be a residual. Lorna, that might be a point that should be very specific in a language of this principle #1, but you're just re-affirming that IHS has to be the principal supplier of services. We don't want IHS to be eroded. Does anyone else have any comments on principle #1?

Principle #2. The rights and benefits that will be made available to all citizens through NHI, must also be made available to Indian since IHS and tribal programs are the primary providers of health services to Indians. IHS and tribal programs must be eligible for reimbursement from NHI when they provide covered services to eligible Indians...

Principle #2 also mentioned the fact that the IHS, now, can provide only about 70% of the absolute necessary medical services needed by the Indians. Do you have any comments to make on this? Is it alright if I go to principle #3? Indian tribal governments must be recognized as appropriate governmental entities for administration of NHI on their reservations. NHI must not give state governments authority or jurisdiction over Indians or Indian Health Boards. Summarizing this, it is saying that the Indian tribal government must be recognized as the appropriate governmental entity for administration of the NHI.

Unidentified speaker: Give an example of that.

Gaylord Fox: What this is saying is that IHS will not have to answer to any state or local governments to get this particular clinic funded. They will get their funding from NHI. So, if they wanted to put this particular clinic on their reservation they are the ones that must be recognized as appropriate government to make this decision. This is the

principle that has been agreed upon as being one thing that Indians want in NHI.

Unidentified speaker: What about those projects that aren't based on a reservation?

Gaylord Fox: Well, this principle only pertains to reservations. Are there any comments on this principle #3? Well, I know there's a bill that just came out of the House Ways and Means Committee on establishing requirements on various types of medical facilities. I don't think this principle is addressing itself to that particular question.

Lorna Patricio: Yes, it does. It says here, "to permit Indian tribes to establish their own standards for reservation day care centers, institutions, and foster homes."

Gaylord Fox: This is specified in this principle #3. The state agency makes the inspections for the federal government. They go by the state guidelines.

Lorna Patricio: That's one of the things we are trying to get away from, so that the tribes can set their own standards.

Unidentified speaker: There is a lot of authority given there. They could use anything if you didn't go by the standards, and rules and regulations, right?

Gaylord Fox: What they are saying is in principle #3, that the wording must be carefully made as not to give too much authority to IHS. They must have established guidelines in order to determine the proper requirements. They can't just do it based on the limited knowledge. But, getting back to what this lady here said, that this particular principle wants to give the sole authority for certifying providers to the Indian tribal government. And, what she's saying is that she thinks this is too broad. All they're saying is that tribal council has a sole authority for certifying providers.

Lorna Patricio: They probably would have to set up their standards so that would apply to every reservation, or organization.

Unidentified speaker: Principle #4. The principle of the Indian tribal self-determination must be incorporated into NHI legislation. That means Indians have the right to determine their own future.

Unidentified speaker: Principle #5 is: NHI must not diminish to Indians any right to health care by the federal government. What that means if regardless of which health care legislation is passed, concerning NHI,

it will not diminish, in any way, those services that have always been provided.

Unidentified speaker: This, more or less, reinforces Principle #1. Instead of eroding your health service, in any way, it's going to have to strengthen it.

Unidentified speaker: Principle #6 is "the rights of Indians living in non-reservation areas must be recognized, and the rights of services protected by NHI". Myself, I'm having problems in the wording of this.

Unidentified speaker: So am I, and I believe that's why they designated that one group just to discuss the urban Indian problems. The rights of Indians living in non-reservation areas must be recognized and their rights to services protected by NHI.

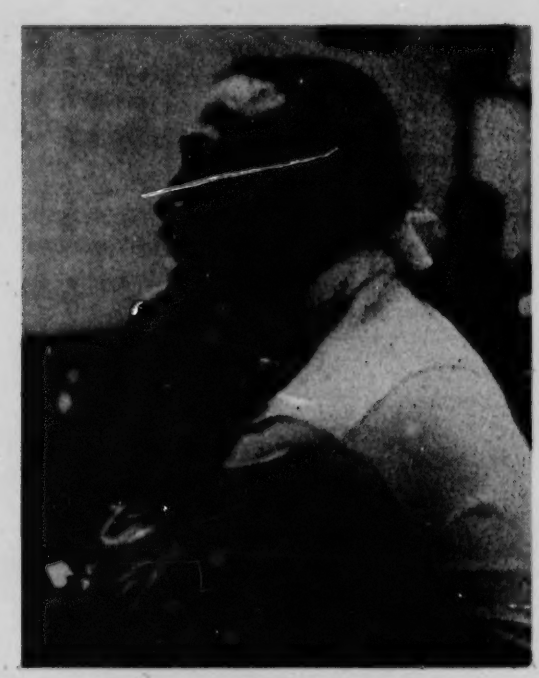
Unidentified speaker: I couldn't define a non-reservation Indian. Of course, that's not part of this principle. It would be more specific if it read, "The rights of all Indians are protected by NHI..."

Unidentified speaker: My interpretation of the whole proposal, the whole package is that what it's trying to do is establish more or less dual entitlement for Indians. Nothing in any of the principles that I've read, or any of the consensus statements have indicated that anything would be deleted, only added to.

Lorna Patricio: I felt that maybe under that principle #1 that would be one of the things to begin to strengthn IHS to be the major financier and the deliverer of services.

SMALL GROUP DISCUSSIONS were utilized as one method for sharing concerns and ideas.

CHIEF EDWIN TANYAN, NIHB member from the Oklahoma area.



NAVAJO AREA health board member, Elwood Saganey.

Wednesday, June 30, 1976
Panel Discussion: P.L. 93-641-National Planning and Resource Development Act, H.R. 2525-Indian Health Care Improvement Act, P.L. 93-638-Indian Self-Determination Act

Lillie McGarvey: My name is Lillie McGarvey. I've been on the National Indian Health Baord for the last four years. It's an honor to be here and to participate with native peoples from across the country in this conference. We have people here from all the Indian Health Service areas. I'd like to introduce Irene Wallace, Chairwoman of the Papago Executive health staff.

Irene Wallace: I was asked some time ago to present a position paper on P.L. 641, National Planning and Resource Development Act. At this point, however, I think it's too late to present our position paper because the law has already passed and been implemented...

What we need to talk about now is how Indian people are participating in P.L. 641 and whether it's working for them. The Papago Tribe agreed to participate on the understanding that any planning for the tribe would be done by the Papago Tribe and that we would be included in the state plans on an equal basis. One of the first problems that we ran into was that from the very beginning we were outnumbered; we have a governing board of 13. We have one vote, and we were outvoted from the beginning.

At this time, I would like to have some of the other people picked at random yesterday, give their views on how they are participating in this law. Hopefully, this will give you an idea on some of the things that are happening. Let me introduce the three people that will be talking: Dr. Jim Felsen from the Indian Health Service, Mike Everett from the White Mountain Apache Tribe and Dennis Tiepelman from Alaska. We'll start with Dr. Jim Felsen.

Dr. Felsen: Actually, I have been interested in 641 for a long time...

The ideal in 641 would have been for Indian people to be recognized as an entity that would engage in separate planning for health, getting equal money, direct eligiblity for all types of demonstration grants, planning funds and so forth. However, in all honesty, I question significantly if the country is going to change this law to accommodate Indian views. It seems to me that 641 is a law not necessarily overly responsive to the needs of Indian people.

What's in the law and what's being interpreted by regional offices and other places are two entirely different things. Now, what's in the law, specifically, is the requirement for review, comment and approval by Health Service Agencies (HSA's) for money to be spent for certain health planning projects, and also money appropriated under specific authorities. One of the authorities that it does not include, is the authority upon which Indian Health Service funding is based. Obviously, there's an educational function to be done.

Now, the second part is that tribes in relation to Indian health, obviously, have been getting categorical money, everything from family planning, alcoholism, general health and various other projects. There is a review and comment authority on this type of demonstration money, but again require no approval by the Health Service Agency. People who think a regional office or group is stepping beyond their authority under the law have a perfect right and obligation to write the Secretary of Health, Education and Welfare, the Regional Office Director and express their concerns. By law, the Secretary will have to respond.

Looking into the future, I am especially concerned with "641" even though you have the categorical guarantee that only review and comment is mandated. The problem is if all of these categorical programs where tribes pick up various money should become block grants to states, then we have got a real problem. It's going to be important that people watch every single piece of legislation to assure that there is a specific split out for Indian groups. I think if we go closer and closer to block grants, there is going to have to be a major political effort to get recognition for our unique needs.

"Position of White Mountain Apaches on P.L. 93-641"

Mike Everett: My name is Mike Everett. I've worked for the White Mountain Apache Tribe for the past six months, as the director of the Tribal Health Authority. I think thatprobably the best way to summarize the White Mountain Apache Tribal position is from a letter dated January 19th. "Since our only concern is the health care needs of White Mountain Apache people and how these can most effectively and acceptably be met, involvement in a state government sponsored health care planning project, which focuses on off-reservation regional and state-wide problems is of little value to us. The following considerations are also relevant to our decision. One, White Mountain Apache Tribe is legally exempt from mandatory participation in Health Services Administration programs as per congressional legislative stipulation in the 93-641. None of our health care planning and funding materials need to be channeled through Health Service Adminstration 3, except for review and comment.

Two, the health care needs of the White Mountain Apache people are not the same as those of other native Americans and non-Indians included in Health Services Administration. We do not believe that two votes on the agency body would allow us to express our needs satisfactorily, in competition with all the other Indian voting interests involved, especially since representation above this arbitrary number is based on population size.

Three, the White Mountain Apache Tribe has established its own federally funded comprehensive health care planning agency. Its mandate from a tribal council this year designed a comprehensive health care delivery system, which will effectively and acceptably meet the health care needs of the White Mountain Apache People.

We consider it wasteful to duplicate efforts and expenditures in this

area of high concern to our people, make no mistakes. Our decision not to participate in Health Services Administration 3 is not a frivolous one. In view of our decision, we expect that no information, statistical or otherwise, regarding health care needs on Fort Apache Indian Reservation, will be utilized by the Northern Arizona Council of Governments in requesting funds under the Health Services Administration program." The letter is signed by Mr. Ronnie Lupe, Chairman, White Mountain Apache Tribe.

In a second letter dated February 3rd, we go on to say the following: "We recognize the needs for cooperation in the present atmosphere of change that characterizes our National Health Care System. Indeed, the White Mountain Apache Tribe has a strong reputation for cross-cultural cooperation in economic, governmental and other areas. Sunrise Ski Resort provides first class recreation for all of Arizona and the southwest.

Our foremost concern has always been the needs of our people and how these can best be met. The proposed Health Services Administration program has not been presented to us in this prospective. We have cooperated in the past, with the state agencies and we will continue to do so, but we will not be dominated any longer."

I think that there are several points. One, we have heard nothing from the state agencies that have been involved in putting together the planning of the Health Services Administration in which we are supposed to be participating, or the others. If I interpret Public Law 641 accurately, that is not supposed to happen. That is, our decision not to participate should be independent of the information we received from the state planning agencies.

The second concern that we have, Dr. Felsen covered under political realities. One of the political realities that we face in Arizona is the state... Those of you in Arizona know what I'm talking about. Our problem in tribal government and tribal programs, both health-oriented and otherwise, that have not only had the best interests of the White Mountain Apache people in mind, but have in effect run directly contradictory to those.

So, in effect, we find ourselves in a bind with Public Law 93-641. We're being forced to negotiate with state agencies, that in the past have not been responsive to our needs. So, our position now is, instead of being forced by the state to negotiate, we're going to sit back and wait and see what happens.

"Alaskan Native Use of P.L. 93-641"

Dennis Tiepelman: I'd like to explain how we involve the National Health Planning and Resource Development Act in Alaska. In January of 1975, we knew the law was signed and that was the first time we heard about what, perhaps, it could do to our different regions that represented the state of Alaska, as well as the natives that resided in those various regions. The result was that we immediately noted that in order

for some act to succeed, there's got to be native involvement. We requested representation and became involved with the planning prior to the actual implementation of this law. We became involved in finding out what the regulations were going to say. It became a battle between the native organizations and the state of Alaska to see who could get the interim federal regulations before anybody else.

The big question that we had in the state and in the rest of the nation was "how are you going to set up the boundaries?" In Alaska, the situation for us was that the state of Alaska had no real boundaires for delivering services. Furthermore, we found the federal agencies had no recognized boundaries governing how services were to be delivered. So we proposed certain boundaries. Alaska is divided into 12 political boundaries and regional organizations, so we advocated those boundaries. Alaska has less than 500,000 population and a Health Services Administration serves up to 500,000. But, we argued regarding the circumstances, such as distances, and other reasons for having more than one Health Services Administration, and we got three. The three Health Services Administrations follow along the native political boundaries that were established, the 12 that I mentioned earlier.

We think that his law could be made to work for us in the delivery of services and health planning. We also planned it so that in the membership on that committee, we got ourselves split among the three and we each decided that we need 10 of our own representatives. As a result, whenever we meet, we have at least 20 members of that board, either native or they feel that they have concerns that correspond with the native population.

We've also been involved with this specific act for the simple reason that no matter how much money we get from Indian Health Service, they always come back and say that we've used up all of the money. The only thing that we do, is try to be aware of all programs, that either apply to the American Indians, or to us as American citizens. What we try to do as a native organization in the state of Alaska, is become involved with long-range planning, and to see if we can interpret what kind of consequences will happen if we go certain ways. We've done that with P.L. 93-638.

Irene Wallace: Thank you all for your fine presentations. Erin Forrest is the Vice President of the Tribal Chairmans Association and Chairman of their Health Committee. He will speak on Public Law 93-638.

Erin Forrest: Ladies and gentlemen, when I was first asked to give this presentation, I was kind of reluctant to do so. And I will share some of those reasons with you. First of all, I didn't think you should be exposed to another session in Public Law 93-638. Secondly, I felt very uncomfortable being asked to explain a law in a few minutes, which took Indian Health Service two days to do unsuccessfully. And, thirdly, I was concerned because Public Law 93-638 excludes certain Indian communities, and it's always very difficult to talk to people who are not involved in the particular law.

I think that the orientation sessions on Public Law 93-638 have been concerned too much with contracts and grants. And I kind of suspect

that the reason IHS dwelled on contracts and grants is because that's where their responsibilities are. To understand Public Law 93-638, and to understand contracts and grants, I think there are three factors that need explanation. One, the history of the act. What brought it about? Two, what did Congress really want to achieve? And three, how does the national policy of federalism relate to Public Law 93-638?

To deal with the first, the history of the act, you have to go back before the coming of the invaders when Indian tribes truly exercised tribal sovereignty. Following the invasion of the country, there was war, in which there was no such thing as tribal sovereignty. Very few people even gave it any thought, because everything was concentrated toward the direction of survival. And then in 1934, Congress passed the Indian Reorganization Act. It was an attempt to restore tribal governments to Indian tribes, with the idea of restoring some of that tribal sovereignty.

In 1975 and 1976, in its considerations, Congress dealt with that question. There was another thing that happened during the great society program. All of a sudden, all kinds of programs were made available to Indian people and they appeared to be totally unprepared. So, what happened is that Indian tribal governments being unprepared, began to appoint committees to do certain things. It wasn't much of a problem so long as those committees stayed at home and did their work. However, many of our committees became incorporated, and completely independent. The tragedy was that the federal government began to deal with the committees of Indian tribes, rather than tribal governments themselves. This delegation of authority, which was necessary at the time, tended to weaken tribal government.

What's federalism? The return of federalism occurred following the great society programs because during that period of time, the government funded almost anybody who could create a non-profit corporation. Federalism is a decentralization of the federal government to local units of government. Under the return of federalism, the government decided that federal grant money should be made available to the local political subdivisions. So, as a by-product of federalism, Congress recognized the need to deal, also, with elected officials of tribal governments. Tribal governments have to exercise greater control over programs designed on their own reservations, particularly over finances.

I think IHS has some responsibilities. I think they have to eliminate some of the indecisiveness within their own organization. Finally, I think only an alert, knowledgable, and dedicated type of leadership can fulfill the dream of tribal sovereignty, of true tribal sovereignty.

Lillie McGarvey: Thank you very much. It gives me great pleasure to introduce Dr. Taylor McKenzie, Director of the Navajo Health Authority.

"Indian Health Care Improvement Act"

Dr. Taylor McKenzie: ...On May 16, 1975, the Senate, passed the Indian

Health Care Improvement Act and it came out as S.522. This was substantially the same as S.2938 that the previous Congress had passed. And then the bill was referred to the House and was introduced as H.R.7852. The language in the bill is identical to S.522.

It called for seven years of legislative life, and included some of the things that Indian people have looked forward to. And, then, of course, you leave the medical school provision, and reduce that to a one year feasibility study.

Title I deals with the Indian Health Manpower and there are several sections to that. One of the health professions, awareness type of activity to make Indian students aware of health programs, health careers, and, also, to prepare them to qualify for those programs. Then the health professions scholarship for students who enter professional schools with certain payback mechanisms. Also, traditional Indian Practitioner or Medicine Man Programs from H.R.2525, we are very pleased to note, have been retained. The bill deals with health facilities, and hospitals, health centers, staff housing and also, talks about sanitary waste and safe water facilities. Title 5 provides for health services for urban Indians, and it's a section where I think we are indeed concerned about Indian unity. Title 6: The American Indian School of Medicine was deleted. It is our position that the Indian School of Medicine lends a great deal of substance to the total bill. The bill was meant to improve the health of the Indian people to the highest possible level.

I submit to you these observations as a sincere member of the Indian community, and health board member who is concerned about the health of Indian people. With that I conclude my remarks...

Wednesday, June 30, 1976
Tribal & Urban Health Board Management - Panel Discussion

Ada White: What we have tried to do in bringing this panel together, was to have representation from the various tribal health programs. We do have represented, today, from the California Rural Indian Health Board, Joe Benitez, on my far right. Dr. Stitt to my left, has been introduced already and Mel Sampson from Portland. Dr. Stitt's position would be to respond and to share his perspectivies as an Area Director who works with tribal and urban Indians. Next to Dr. Stitt is Lillie McGarvey who will be presenting the kind of structure we have operating in Alaska. Left of Lillie is Don Aragon who is the Chairman of the Seattle Indian Health Board. He is representing a viewpoint and the involvement from the urban scene. George Platero is representing the National Indian Health Board.

This is going to be a session where we're going to have some audience interaction with the panel. Following the panel presentation, we will be breaking into smaller groups. Joe Benitez, will you share with us what your program is about.

Joe Benitez: The California Rural Indian Health Board was established in 1968, because there was a health need in California that was not being met. This was primarily due to the fact that in 1954 and 1955, Indian Health Service pulled their services out of California and certain bills were presented to the state legislature and congressional people. It is a fact that the state of California has had to take care of Indian health needs and provide health care for Indian people, being from the reservation or not.

It started out as a nine member project with some of the program being established in north, central and southern California. Each of the 16 projects must have established health boards of their own. There is sometimes a misunderstanding between the local health boards and the larger health boards, because of the difficulty in delegating authority to the local boards. The main thing that the central office is established for is, as I mentioned before, to monitor the appropriations that come to California Rural Indian Health Board.

We do have a great influx of Indians that come into California. This increases the need for medical health care because of the non-existent Indian Health Service in California. The basic philosophy, as I see it with the California Rural Indian Health Board organization, is to get Indian Health Service established back in California.

PANEL MEMBERS Howard Tommie, NIHB chairman; Joe Benitez, CRIHB and conference coordinator; Lorna Patricio, NIHB; Elwood Saganey, NIHB and Mel Sampson, NIHB.

Ada White: I would like to introduce Lillie McGarvey and she can explain how the Alaska health system is operating. They have two boards that I am familiar with, the Alaskan Federation of Natives and Alaskan Indian Health Board.

Lillie McGarvey: Under the Land Claims Settlement Act, Alaska was divided by Congress into 12 native regions. Each region was set up as a profit making business corporation and most of them are doing very well. Under the law, the corporations were prohibited from using the money that they were to receive for social service type programs. Each region has formed a non-profit corporation which is equivalent down here to a tribal organization. The non-profit organizations have set up their social type services in education, health and welfare. There is a centrally located non-profit organization called the Alaskan Federation of Natives that gives technical advice to the non-profit organizations in the regions.

In Alaska, we have several kinds of health boards. Originally in 1969, the area directors established the Native or Indian health boards, so that the grass root people could have involvement in the planning, implementation and monitoring of the health care and services that Indian Health Service is providing.

The service unit boards send representatives to the area boards and the chairman of the area board is Alaska's representative to the National Indian Health Board. After the passage of the Alaskan Native Claims Settlement Act, the area boards expanded from seven to twelve, including a member from each of the 12 regions.

Some of the regions in Alaska formed health corporations. They set up a regional board, hired staff and began contracting for services that they previously had been getting from the Indian Health Service. And now I'd like to introduce George Platero, a NIHB board member.

George Platero: It has taken quite a battle to fund through Washington and it took a lot of time to form NIHB. The 12 members are assisting Emery Johnson, the Assistant Surgeon General in the Indian Health Service and there have been many things occurring. I want to say that many things have improved, but we're aiming to improve the Indian Health Programs.

We do have an office in Denver, Colo. with a staff of five at the present time. The board members operate from their own areas. One staff person, Janis B. Dukepoo, is working with a program funded by the Donner Foundation. This is a planned program to provide technical assistance and training to your health boards. The many tribal health boards present show that there is a lot of interest in a health conference. I believe that we all realize that we can work together.

Ada White: Thank you. The question is, How do we have input in the planning process of the Indian Health Service? We have with us, Don Aragon, who is the Chairman of the Seattle Indian Health Board, and I would like to ask Don to share some of his activities with us.

Don Aragon: We've heard from a lot of people in other areas about their environmental problems, sanitation problems and transportation problems. These problems also exist in the cities. We have problems of Indian ghettos, in some urban areas, and we have problems of transporting patients to and from the necessary medical facilities that exist.

In Seattle, we have developed a complete and comprehensive medical and dental program with social services, and alcoholism programs with the in-patient care center soon to be opened. In February of 1970, a few people were able to organize an urban health center. Unfortunately, a lot of the needs that they solved then, still exist, but today to a lesser degree due to our presence. We are affiliated with a university and with major colleges in our area. Indian students can come into field experiences with our clinics. We have other on-going training programs in our organization. We have professional medics, nurses, practitioners and social service counselors in the alcoholism program.

In the near future, we hope to have maternal and infant care, plus a mental health program which is not alcohol related. If the government can recognize the problems of the urban Indians, we can identify the needs and come up with the proper delivery system.

We welcome anyone that wishes to come and see how we have organized ourselves and how we operate our health delivery system. The Board of Directors for the Seattle Indian Health Board does not interfere with the operations of the administration. It is my feeling that once the board interferes with the operation, they start undercutting the authority of the executive director which leads to chaos. Our Board of Directors is committee-structured; issues are referred to a particular committee. As Chairman of the Seattle Indian Health Board, I believe a lot of our success is due to the fact that we have Indian practitioners in our clinics. Thank you.

Ada White: One of the questions that has been asked from one of the urban members of the audience was, "how he might be able to tie in with activities of the National Indian Health Board?" I think the counter question is how do we provide information to urban leaders and their organizations?

Don Aragon: The Seattle Indian Health Board is a local health board that is affiliated with the National Health Board.

Ada White: This leads us to one of our participants who has been asked to share his views as an area director. If you are a health board member or health board staff, just how do you satisfy the information concerns of the people whom you serve? How does the area office respond to the request for training? Dr. Stitt, how do you see the area office working with the tribal health boards?

Dr. Stitt: I think that Ada opened the door. Let's start with a couple of things. Indian Health Service says that an organizatons must work

in Indian communities with tribal government. Now, I don't particularly have any alternatives.

It's impossible to deal on an individual basis with all the people who make up the so called "grass roots". So, I think we have no option, no alternative, but to deal with tribal government, or with a group.

The tribal government was established for that purpose. I think here lies the basic reason for the existence of health boards. An organization body that has been established by tribal governments and has been given some specific responsibilities and I would hope, among those specific responsibilities, there are specific authorities.

I think it's possible, unknowingly, for area boards and national boards to do something that could well effect individual tribal sovereignty. It will take time and experience for boards to operate well. I think one has to assume that Congress will pass the Indian Health Care Improvement Act. It's a matter of having both the scientific knowledge and the materials available and then getting people to use them.

My honest opinion, also, is that at this point, the type of planning that is necessary to effectively use the money that's made available in the Indian Health Care Improvement Act does not exit.

Preventive health care is a place where it's fundamental that we have participation and cooperation. We're talking about an individual doing certain things, many of which have to be self-motivated. I think it's imperative that the people who serve on boards be permitted to serve for a long enough period that they can become familiar with the issues, either local or national. I think that boards have to be careful with resolutions and their impact. The fact still remains that we're talking about Indian self-determination, Indian management of Indian affairs. If we're going to put together a good first class health service delivery system, then there will have to be cooperation. We also need a structure that can distribute information, and we need to move in a united fashion towards this goal that we are all seeking. Thank you.

Wednesday, June 30, 1976
Tribal & Urban Health Board Management
Small Group Sessions

(As with National Health Insurance, the participants once again met in small groups to discuss Tribal & Urban Health Board Management. Transcripts of several such sessions follow.)

Ellouise De Groat, Chairwoman
Tribal & Urban Health Board Management

Ellouise De Groat: The charge, as I understand, for this afternoon's session has to do with the Urban and Tribal Health Board Management... Specifically, we will stay within the four categorical areas that have been given to us on a chart, Health Board Organization, Health Board Functions, Health Board Training Needs, Health Board Relationships in cluding Tribal Indian Health Service Area Boards and the National Indian Health Board.

Ellouise De Groat: ...But I think to begin with maybe each of us can share as to how our health boards were organized. I might go ahead and start with the Navajo Area Health Board and explain how it is organized. A Navajo Tribal Council resolution mandated the foundation of our health board. For a long time the tribal council also had a health committee. We have 17 members on the area health board.

There may be others that have a better model, and I think here the group discussion is really going to be based on the health board organization and the concerns that you people have. Later recommendations will be taken back to the local group within the general session.

Rita Lorenzo: My name is Rita Lorenzo and I am the Chairperson for the Zuni Health Board. We just recently organized our health board. Before we changed governors, we had never had a health board. We now have a seven member board. Most of the board members are in the health realted areas. The work that I do for the health board is voluntary. If I attend meetings like this, I have to get approval from the council. Our service unit just recently opened a new hospital that also serves the Navajo people. We are a liaison between the tribe and the hospital.

Ellouise De Groat: Your health board is one that just recently was established. I think there are some health boards that have been in existence for quite some time. I know one of the problems has always been the function of health boards. What is the function of health board members? Both on and off-reservations, board members are functioning in an advisory capacity. What are some of your feelings on that?

Unidentified speaker: Is this on a national level or local level?

Ellouise De Groat: I think we can speak to both. Are you from Alaska?

Unidentified speaker: Yes. As Lillie McGarvey pointed out, Alaska was divided into several regions, both profitmaking and non-profitmaking. Our health board in southeast Alaska was formed in 1968 by mandate of the Alaska Native Brotherhood Convention. The Alaska Native Brotherhood is probably one of the oldest organizations in the country and was formed in 1912 for the purpose of fighting for the rights of the Alaskan Natives as citizens. Our health board has taken on a responsibility now as an advisory council to the Indian Health Service.

Unidentified speaker: I am from Alaska too and I am on a local board and our local board is just getting organized. I think probably we'll be in an advisory capacity on that board also. It's frustrating and it is disheartening to stay on an advisory board for a long period of time when you can't make the changes that you want made.

Ellouise De Groat: I think some of the problems that are seen within the health board are the function of how far do you go, how much do you get involved, how far should Indian people go in terms of making decisions? Should we be a decision-making body, a policy-making body, and in an advisory capacity?

Nicky Solomon: I would like to make a comment on the Aberdeen area, Winnebago, Neb. Our tribe has seen fit not to form a health board or health committee. The Community Health Representative in our community functions as the liaison between the hospital and the tribal council. However, it seems there is a drive by Indian Health Service to give funding specifically for setting up health boards. Now our tribe has said we don't want this, we see it as setting up another entity, another faction in the community. It appears to me as though the Indian Health Service wants boards, the tribes are not requesting them.

Unidentified speaker: We are under the Colorado River Service Unit and that includes four different tribes plus Sherman Indian High School which is located in Riverside, Calif. The only way our quarterly meetings are funded is with the idea that we are in training. A lot of our meeting time is taken up with training people coming in and talking to us about things that sometimes don't even concern us, and then we don't have time for reservation health problems. Indian Health Service did ask us to form as an advisory group. When we did start giving advice or telling them about some of our problems they didn't like it. Therefore I think there is a need for an understanding of what the health boards are about.

Ellouise De Groat: What I am hearing now with Nicky is that the government is always standardizing and expecting uniformity from Indian people. There are many different needs and different unique settings. In one area health boards have been organized since the tribal council was established. I think the thing that I'm hearing is that the Indian Health Service should not set uniform policy for Indian health concerns.

Unidentified speaker: We need to have people with health boards long enought to know what is going on, and to be able to have more organization. We did put in our constitution and by-laws that members would serve for three years no matter what chairman was in and this has helped us.

Unidentified speaker: I am from the Quechan tribe from the Ft. Yuma reservation and we don't have a health board but we do have a Phoenix Area Health Board. We do have our own health committee. Last year was our first experience with a committee.

Our service unit director works with us very well and he will listen to whatever we say. Our member from our health committee is on the Phoenix Area Health Board through a resolution from our tribal council. It serves the Cocopah and Quechan tribes so we have to take turns to see who is going to serve on the Area Health Board.

Ellouise De Groat: Do you have by-laws?

Unidentified speaker: No, not yet.

Unidentified speaker: Our chairman is our representative to the Phoenix area.

Unidentified speaker: I am with the Child Health Program from Shiprock, N.M. and the National Indian Health Board has always interested me. I look at it as a way of involving Indian people in health programs and health boards. People representing Indian communities have input into health services. For once we have a chance to say how we would like to have programs delivered to us, but I think the whole process involves education.

Once we get organized as a health board, I think the health boards themselves need to be educated to the whole process of Indian Health Service. Areas have been mentioned: regional, national and tribal.

Nicky Solomon: Health boards have received training and now we are at a point where we don't want to drink milk any longer we want some meat. We want a part of the action and want to help make decisions. We want to select the key positions.

Ellouise De Groat: It is not just the board that should be trained. The area directors have to be trained to what Indian philosophy is all about and what the Indian people want.

Unidentified speaker: I would like to make another comment. I think the board's role, as I see it, is to represent Indians and two, administrative mangement of the health delivery systems, and I think third and the most important, is monitoring the health delivery system as a quality controller.

Ellouise De Groat: I think we have covered health board organization and the health board functions. I hear that the consensus here is that health boards should be more than in an advisory capacity.

Unidentified speaker: I can't help but think that the health board at this time, if they are just getting started would be an advisory board. If you have gained the knowledge of the system then you can become a policy making board, but if you are not aware of the Indian Health Service's organization structure you can't make any policies.

You have to make a distinction between professional board members and lay members. Professional people generally know the operation of the business so that they can more or less determine policy, but a layman on the board generally acts in an advisory capacity.

Ellouise De Groat: I agree wholeheartedly with you. Dr. Johnson, himself, has made a statement that the Indian health boards should be more than advisory, but again the interpretation is back at the home level with your area directors, and your service unit directors.

One of the things that I hear is that the board needs to learn the whole IHS general organization structure, policy making, budget appropriations, personnel policies, EO policies and grievance procedures, is that right? Are there any other suggestions on training?

Unidentified speaker: Is there funding for training?

Ellouise De Groat: There is funding for training, there is a lot of money for training. $280,000 goes to Alaskan Natives, there is money for training.

Nicky Solomon: I know that the Cook-Inlet region which is one of the regions under the NCSA just got money for health board training.

Ellouise De Groat: There is money. Couldn't that training be not only open to health board members, tribal council members and other people within the community?

Unidentified speaker: I think that if you connect the training with a university or some small college you get some accreditation for your efforts in learning.

Ellouise De Groat: The fourth one that has been charged to use was Health Board Relationships to the tribal government and tribal organizations. Each is a specific relationship. I think one thing that is left out that is very important... Is how do we relate to Regional offices?

Unidentified speaker: Is there a Regional Board?

Ellouise De Groat: No, Regional offices like in Navajo, we answer to three regions, Denver, San Francisco and Dallas. How does the board relate to those three regions? The Regional offices are mandated by federal regulations to regulate activities.

Dr. Care Hammerschlog, M.D., Chairman
Tribal & Urban Health Board Management

Dr. Hammerscholg: We are going to talk to each other about health boards -- actually I would like to talk to you about whatever you would like to talk about, but we do have a charge -- do you know what the charge is? It is what we are asked to this afternoon -- I would like to know something about how your health boards function, something about your perception

of the training needs of health boards, and essentially how they work. Also what you would like from the National Indian Health Board -- that briefly is how I understand it. Is there anything else you would like to talk about? Is there anything you would like to ask me? Do all of you represent health boards? Do you know anything about the health boards from the areas you represent?

Unidentified speaker: If there is a health board representative here, maybe we could start with how they are organized, and what their problems seem to be...

Dr. Hammerschlog: We are going to talk to each other this afternoon -- we haven't yet picked a subject, but we are going to change the format from what has proceeded the last couple of days and we will speak in a small group. Our task is health boards -- what do they do -- what do you want them to do -- and what do you see the future holding in store. How can NIHB be helpful, how do your health boards work, are they effective, do people listen to what you say, to what extent is it true that you as tribal people have some input in terms of health decisions, and health services for Indian people in the community from which you come. This is the task as I understand it.

Is that something you would like to talk about? Do you want me to talk? I will talk about anything at a moment's notice, but I am anxious to hear from you. Are you familiar with how health boards work? Service unit health boards? Do you know that the Indian Health Service, and the policy of self-determination, suggests that Indian people will have the ultimate say so in all decisions that ultimately affect the health care of Indian people? Are you familiar with that in terms of self-determination? And you know that health boards are ultimately going to be responsible for making decisions about how the hospital runs, eventually who gets hired or fired, what doctors you want, whether you want to spend the money for a new x-ray machine, or whether you want to get a new dental chair?

And the question is to what extent do they determine policies and issues, to what extent do your health boards really have something to say, or are they just rubber stamps? You know somebody else says what is going to happen and then eveybody else agrees -- what are your expectations from the National Indian Health Board? Do you know what they do? Those are questions that I would have.

Timm Williams, Eureka, California: There are several things I would like to ask in addition to those questions. One question is the definition of Indians that Indian Health Service recognizes. In the law, Indian Health Service recognizes Indians that are recognized by the government, or what they consider to be recognized tribes. That means recognized tribes by the Department of the Interior, established by constitution and by-laws set up by the Bureau of Indian Affairs, or whoever sets up the constitution and by-laws. The Indians end up rubber stamping these by-laws, and a lot of the by-laws were not written, originally by the tribal organizations.

So, when Indian Health Service says we are going to deal with Indians, and I come from California, a terminated state, the same as Oklahoma, although there are tribes and 76 reservations that are recognized in California with tribal organizations only about four or five of those reservations are recognized by the government as tribal organizations. Indian Health Service says: "look, you serve whoever you want to serve, and we will close our eyes to the people you serve." And I am saying in answer to that, "I want an open door for my Indian people. I want to come through the front door for my people." I want a confrontation - how can I hold Indian Health Service to anything if I have to come through the closed door? And then, I'm beginning to wonder, how many other Indian tribes throughout the nation are related to in the same manner, or is it just applied to California?

Dr. Hammerschlog: This has very little to do with the primary task of this afternoon. And that is health boards, health board management, and to what extent there is going to be the exercise of Indina control over Indian Health Service. Well, we have the question "who is an Indian?"

Timm Williams: Well, who is an Indian then? This is one that has been skirted since IHS began. They refuse to identify Indians.

Dr. Hammerschlog: Let me make it very clear, I do not speak for the IHS... If you want to talk about eligibility, and reservation -- urban types of crisis, and we have those in Phoenix, as well as anywhere else, that's an area we can attack. By attack, I mean deal with and talk about. My purpose would be, how does it relate to health board representation. Perhaps you can help me with that. Well, perhaps somebody else can.

Timm Williams: I helped to organize Indian urban health boards in San Francisco, and Los Angeles, and worked very closely with those boards. But I also am a tribal member of an Indian reservation, which the government has classified as an unidentifiable group.

Dr. Hammerschlog: How do they provide services to you?

Timm Williams: They don't provide services to us. Neither does IHS provide services for us. CRIHB, California Rural Indian Health Board happens to speak for the Indians, which is not, you know, an Indian Health Service outfit. Indian Health Service pulled out of California in 1955. Indians since 1955 have been fighting, in California, for their rights.

Dr. Hammerschlog: Well, let me ask you, what would be your ultimate wish?

Timm Williams: My ultimate wish is that IHS take care of Indian health

needs. Ihe uses CRIHB as a self determining factor. They're going around to other Indian tribes and they say "look what CRIHB has done on its own".

Dr. Hammerschlog: And, who should be responsible?

Timm Williams: The federal government should be responsible. They're talking about taxing the Indians for National Health Insurance and my answer to that is the Indian already paid taxes for health care.

I want to know whether I'm a ward to the government, and whether the government is going to take care of my people. I want to know who I can go to for assistance. Indian people have to start identifying Indians.

Unidentified speaker: What has been the position of the National Indian Health Board?

Timm Williams: They haven't addressed themselves to it. For three years back, the urban Indians were asking for a seat on the NIHB. That seat has never been provided for them. There are no urban Indian representatives on the NIHB.

Dr. Hammerschlog: That's an issue we can address. We cannot address an issue, it seems to me, here of who is an Indian and how we deal with the urban-reservation dichotomy and how we deal with th disen-franchisement of when people leave our reservation communities to establish themselves in non-reservation communities.

Timm Williams: I agree with that but, I think that this group can make recommendations regarding the needs of the Indian people.

Dr. Hammerschlog: How do we adequately represent different franchise groups?

Unidentified speaker: The tribal groups are recognized by the federal government; many of the tribes in California, and essentially the tribes in the east remain only in the minds of men.

Timm Williams: And, also the tribes in Oklahoma. We're talking about how effective do you think a board would be, if it was made up of disenfranchised Indians, compared to a board made up of recognized Indians.

Dr. Hammerschlog: But, you're asking how the National Indian Health Board is going to deal with the question of disenfranchised Indian groups? Will NIHB recognize disenfranchised Indian groups? By those, we're talking about, not legally sanctioned groups?

Timm Williams: As one, yes. And urban Indians as another.

Dr. Hammerschlog: Well, we can recommend it again. NIHB is certainly not going to define an individual who is not an Indian. I mean our own people, themselves, cannot define who is, or who is not an Indian. 60% of the out-patient services of the Phoenix Indian Medical Center are delivered to urban Indians. Many of our reservation people have strong feelings about that. Feeling that with limited health care facilities available, limited medical staff, limited diagnostic personnel, that perhaps they need to get "first dibs". Of course, this comes as a bit of a surprise to you.

I mean I'm not going to lay a heavy number on your head. We have one difficulty getting our own thing together, much less having the federal government recognize who we are. We can all see 10 people disagree. The question is not who is going to make a definition, but how is NIHB going to respond to the clear cut needs of the Indian people? So, that's one question we want to ask. Do people share Timm's concern? I mean, are we all on the same wave length? You know what we're talking about? What would your recommendation be?

The concern is, how are we going to deal with those groups who do not have any legitimate entree? And they, essentially, have to use the back door. You get seen, but nobody publicizes it. People kind of take care, but it's as if they are doing you a favor, rather than something that is obligated, by treaty obligations essentially, more than 200 years old. What recommendations do you want to make to NIHB?

Timm Williams: The NIHB members should have urban areas on that board.

Dr. Hammerschlog: Do you want to make some form of a motion? Would you move that this group make the recommendation to this meeting, that National Indian Health Board have a urban Indian representative on its board? I may not be saying it right.

Timm Williams: I would say that. Or at least consider it.

Dr. Hammerschlog: Well, then you can made a strong recommendation.

Timm Williams: Then I would suggest that they place one on that board.

Dr. Hammerschlog: Does anybody disagree with that?

Unidentified speaker: I do, to some extent. I think that one of the difficulties I'm having in trying to think this thing through is that, and I've only had a very short experience in an urban setting, and that was Seattle for just about nine months. First of all, to maintain whatever strength or rights we have on the reservations, we have right because we have a tribal government there. We have some

definition of boundary. We have, you know, all of those things that are specific to reservation.

That does not mean that the people in the city are any different than those people on the reservation, but they live in a different place. The tribe cannot exert its authority into the city. There are all different kinds of social systems operating in the city. And, if that's true, I think it's unrealistic of us to think that those of us who will live in the cities can expect every right that is given to the reservation Indian.

Dr. Hammerschlog: Does somebody else want to address that?

Unidentified speaker: What good will it do if the NIHB is made of representatives of the area health boards or local health committees? I think an important question is how is membership determined?

Timm Williams: I think it would make a big difference because from my own experience serving on the National Health Board, it was made up of Indians who came from tribal, or recognized tribes. When decisions are made, they are made without the urban Indian consideration, unless somebody wants to take up the fight from a tribal area.

Unidentified speaker: I think my recommendation would be to recommend this to the National Health Board, so the advisors could explore this issue.

Dr. Hammerschlog: But, I'm not sure what the sentiment of the group is. I mean, that's the sentiment of two people. Where are the rest of you?

Unidentified speaker: As far as I'm concerned, I really don't know what NIHB is doing, and what their real function is. Including an urban on that board, it would be nice. However, I'm not really sure what kind of ties, or communication that these urban people would benefit from. I've never seen it at work.

Unidentified speaker: That's what I mean by saying, leaving it up to them to explore. We're not here to solve the problem. We can recommend that the NIHB explore it, and see what alternatives they come up with.

Dr. Hammerschlog: Diane is also raising another question. I'm sorry.

Diane Porter: Well, I see that it's very important in identifying the Indian blood, because if this National Health Insurance is passed, you could have a flock of 100 Indians coming in to get these services. There has to be a definition. There was a National Indian Conference

in Phoenix, a few weeks ago, and the group from Connecticul from unrecognized tribes proposed the question of defining Indians. We wasted a lot of time. I as a Board member am trying to improve services to Indian people and I think that we should really concentrate on that.

Dr. Hammerschlog: I agree with that and will arbitrarily make that decision. It seems to me that we're not going to settle within the next 35 minutes who is an Indian. I mean everybody is going to have a Cherokee grandmother in another 10 years and it will be impossible to tell...

I think what we are talking about this afternoon is addressing those questions over which we think we can have some influence and perhaps leaving those questions that others have wrestled with, in far bigger meetings, because they may not be able to be dealt with here, and now, where the nature of the primary task is, "what are we going to do about health boards", are health boards effective? How can NIHB be helpful? Do they meet your needs? To what extnet do you have training needs? And then that may be something specific in terms of the primary task, which we have been delegated. Let me make it clear, I would like to come up with a recommendation that we could send to the president...

What do you want from NIHB? Do you know what they do? Do you know what their charge is? Do you know what their primary task is? How can they be helpful to you? Do we have some people from NIHB who can tell us?

Unidentified speaker: I think that a lot of people are ignorant in that area. Just what is their function?

Janis Dukepoo, Chairwoman
Tribal & Urban Health Board Management

Janis Dukepoo: NIHB Staffperson: The National Indian Health Board is funded from the Donner Foundation for $60,000 to do the planning this year for a national institute to train urban and tribal health board members. My task this year has been to contact all of the Indian health boards that I can locate, and to find out how these health boards are made up, also what you're doing, how many health board members you have. I may have been in touch with some of you if you are health board members, or if you belong to a health organization. I couldn't write the planning for a national institue without your input regarding the kind of training needs you have as health board members and how you would like to see a training institute set up. What I would like to see happen today is to give the National Indian Health Board some input, for example, do you have training needs? You have already done that for me, in a sense.

I have written to some health boards, this year, but I am just one person, and I can't get to all of the health boards throughout the country. Right now I am in the final stages of setting up the institute. Do you have training needs and would you like to have an institute? There

are 35 different Indian health boards represented at this conference. While you're at this conference, I'd like to get some direct answers from the health board members. Do you really want an institute, or would you rather have your training come from the Indian Health Service.

Some boards want training from IHS or others have private consultants to provide training. If so, do you have the money to send board members to a training school? For how long? Or, do you want trainers to come out to your localities? Those are some of the questions that I need to have answered, because I don't feel that I can provide the answers.

Unidentified speaker: I would like to comment on what she said. This is one of the things, when we came Monday, that should have been pointed to us. I'm for it. I think that we do need the institute. I would support it all the way, because I think that it's needed. I think the Indians need that kind of thing, and I would fight for that. But, that's just one aspect. Because it wasn't clearly stated, at the beginning of this conference, that we were going to resolve whether or not we needed an Indian institute to provide training. And now we're finding out what the needs of this conference are and we're into our second day and almost to our final day.

Dr. Hammerschlog: I can share your concerns, but let me try to summarize if I can, at least the role of NIHB. Indian Health Service provides, whatever service they provide, to many kinds of Indian communities. There had been a policy with the Indian Self-Determination Act that says that no decisions will be made for Indian tribal groups without Indian input, so that groups were developed, health advisory boards, in most reservation communities. O.K., we have urban tribal boards, as well, to deal with kind of larger settings. There was at a local service unit level, an advisory board, made up of members of the community who sat in on the advisory board who were supposed to provide input with regard to decisions regarding health care on whatever the hospital did.

We've placed people in positions to make decisions but we haven't taught, in many ways, what kind of questions to ask. Nor have we provided our people with the kind of background and training, that would not only legitimize them, but enable them to ask the right questions to really put them into positions of power. By and large, they have been figureheads, and rubber stamps.

NIHB serves as an advisory to IHS, Dr. Johnson, correct me if I'm wrong. He says, no decision will be made on a National Indian Health Service level, for which he is responsible, without getting input from the National Indian Health Board. The National Indian Health Board wants to get input from these advisory boards, so that they can advise Emery Johnson. Am I saying that clearly so far?

Unidentified speaker: It's a very important statement you just made about Johnson and the National Indian Health Board...

Unidentified speaker: What you just said is that there would be consultation before Emery Johnson would take action on anything.

Dr. Hammerschlog: O.K., perhaps somebody can clarify that for me. Do you know, Janis?

Janis Dukepoo: Yes, the National Indian Health Board was set up to serve as an advisory board on a national level, just as the service unit boards are advisory boards to the areas. The people that we communicate with at these quarterly meetings are the Council of Area Directors and Emery Johnson. The National Health Board and the Council of Area Directors talk about almost every major decision that affects Indians in the health area.

Dr. Hammerschlog: Dr. Johnson solicits that input...

NIHB has not, essentially, solicited input from advisory boards; and advisory boards, I think, have very little knowledgability about what NIHB does. The task seems to be, at this conference, to share what it is the NIHB potentially can do, and to inform people at local advisory board levels, of the existence of the organization, and the potential power that it can yield.

Unidentified speaker: I agree with you. I served on the National Indian Health Board so I agree with your interpretation of what that board has to do. The policies of the IHS are unclear to everybody and this policy changes on a year to year basis. The program of IHS was set up with area representatives, area boards, but Indians have evolved since then. They have educated themselves, and Indians are beginning to open their eyes to Indian Health Service and what it does provide. And, when we say "Look, these are some of the new areas that we think Indian Health Service should work on," the first thing that we get thrown back at us are a bunch of laws and someone saying, "Look, don't open your eyes again, I mean, close your eyes, and we can serve you. And as long as you don't stir up a lot of fire here, we can administer your little tea pots of money." I would like to support IHS 100% if I could rest assured that IHS would go in, and battle and lobby to protect Indians, and give them, instead of 50% health care, or 70% health care, 100% health care.

Dr. Hammerschlog: I don't even know Emery Johnson personally. I do know that he solicits input from NIHB. I think that, potentially, it has not only a politically powerful force, but can serve to effect lobbying.

Unidentified speaker: None of our projects happen. The money dribbles in and we fight for tooth and nail. All right, but we do not have money for training. There's just not money available for training. That was one of the reasons why when I received your letter about the training institute, I was very grateful, you know, and was able to give you some kind of feedback. I see the bright light shining at the end of the dark tunnel: Training for our board.

Dr. Hammerschlog: Can I just make that in terms of a recommendation from this group? What I hear you saying is that what you would like from NIHB is a statement of their primary task. What are we about? What potentially can we do? And that they send that to every Indian Health sensitive organization in the country, in terms of where they stand, and what potential kind of things they can do and what they see as their primary task. Is that correct?

Unidentified speaker: Most definitely! That's good planning.

Dr. Hammerschlog: Can everybody agree on that?

Several speakers: I agree.

Dr. Hammerschlog: It's an information sharing function. This is who we are, this is what we can do, and this is what we need.

Unidentified speaker: Well, I was wondering, you're putting a lot of emphasis on TA for boards, area advisory boards. IHS is doing the same thing and CRIHB likes to think they provide that. Now you're providing it. We've got four areas. Why is there a duplication?

Dr. Hammerschlog: It doesn't mitigate against informing you what potentially is available. I mean, each local group will be able to decide what training opportunities they would like to avail themselves of. It seems, it's important to me, however, to recognize that theirs is a national group, and that you may be able, somehow, to utilize that service, or if they solicit your input, that you know who you are talking to, and potentially what power they have.

Janis Dukepoo: Those are my feelings. If you don't feel that you need training, that's fine. What we need to know is that you don't need another training program, that you can tie into private involvements or IHS.

Timm Williams: I would like to make a comment here. Now, the local boards have input in the delivery of health services. However, at the area level, which would be area boards, there I would say, is one of the rubber stamp type of things. This is because the area office has their budget all fixed. They want us to review it, and approve it. But we really don't have the actual input on what goes in the budget, and I think we need this very much.

And then also, we need to get training money. Because yesterday here, they were talking about legislation, and all sorts of things. We really didn't have any kind of information. The National Indian Health Board didn't send any kind of information, beforehand, to the area boards, and we were all lost as to what comments we should make. I think they should get the important information on legislation to the

boards. And then the urban groups need support for their recommendation to have a representative on the National Indian Health Board. After all, I feel that they are still a part of our communities. I mean, they left the reservation for their jobs and I don't think we should penalize them. (Agreement in background).

Several speakers: Right, that's our second recommendation.

Unidentified speaker: Are you talking about urban rights?

Unidentified speaker: Right!

Unidentified speaker: Well, I concur, because our people are just desperate; there is not health care for urban Indians.

Dr. Hammerschlog: Is there a consensus ir this group that there be a landless Indian delegate to the National Indian Health Board?

Unidentified speaker: Yes, two forms of representation to the National Indian Health Board. One being urban, and the other being landless.

Unidentified speaker: But CRIHB has both of those types on our board.

Dr. Hammerschlog: Well, Joe Benitez is a member of CRIHB and he does sit on the National Indian Health Board. O.K., is there an urban representative on the NIHB?

Janis Dukepoo: No, Joe Benitez is considered a tribal representative.

Dr. Hammerschlog: Is the consensus of this group, then, that there be an urban representative on the National Indian Health Board?

Unidentified speaker: Two, there should be two.

Dr. Hammerschlog: Well, I was hoping that we could get a consensus of one. O.K., is there a consensus in the group, just our small group, that this group make a suggestion that there be an urban Indian representative to the National Indian Health Board? We're not specifying from what geographical area.

Unidentified speaker: We should also consider that there are some Indian reservations that are large enough, in various states to be represented on the NIHB, which want to be represented. What about those? We just had a meeting with the NIHB people yesterday, and they said

that they would have to hold off on our request because they have enough representatives already.

Timm Williams: Another question should be put to the National Indian Health Board. Either the states be divided into regions and the person elected for the region represent all of those people within that region on the National Indian Health Board.

Dr. Hammerschlog: That's an interesting proposition. How is representation to the National Indian Health Board determined?

Janis Dukepoo: It is determined by the IHS delineated areas. For example, Aberdeen, Billings, Alaska and so on.

Dr. Hammerschlog: So it is geographically divided. Each area, each IHS area, provides a representative.

Unidentified speaker: Right! So that those tribes that want representation are within the region already? The, they should be taking their problem to the National Indian Health Board member who represents that region.

Unidentified speaker: O.K., going back to the same issue. There have been certain areas which were not consulted before the representation was decided on NIHB.

Timm Williams: I would say once an organization has been established, for example, the NIHB has now been established, it's up to the Indians to cause NIHB to amend its by-laws, and its constitution to support the Indians who are not represented by that board now. If we're going to give power to that board, and it's going to be a power structure to IHS, it's up to the Indians of the community to make that board respond to their demands. For example, not to seat somebody time and time again, who was an original board member.

Dr. Hammerschlog: So far, we want an urban representative. We haven't yet decided where that urban representative comes from. But, we have made it clear that if there is an urban representative, that part of his task would be to inform all urban groups, that it is he who represents their interests, to this national organization. We haven't decided how such an individual would be elected, and I have a feeling that's going to be very difficult for us. But, I have a feeling that if we come up with a recommendation, at least to start, then we can deal with the mechanics perhaps later. Is there an objection to an urban representative to the National Indian Health Board?

Unidentified speaker: I have one more question when you get through with that. I'd like to know in how many sections NIHB is divided or represented.

Dr. Hammerschlog: There are 12 Indian Health Service areas.

Unidentified speaker: Can you get additional members on that board?

Janis Dukepoo: No, right now it's set up for 12 members, unless the constitution is amended.

Dr. Hammerschlog: Now, that can be a recommendation from this group as well. I mean, clearly, if you want an urban representative, you are making an amendment to the by-laws of NIHB. I think the mechanics we're going to have to leave, in some way, to the 12 areas. I do think that if you want to make an amendment to the by-laws to add an urban representative, this can be a recommendation. Well, you're making two recommendations. One, to amend the by-laws to include more than 12 people, and at least one additional person be an urban representative. Am I stating that clearly...?

Is there anybody opposed to a recommendation from this group that the National Indian Health Board have an urban Indian representative? It is unanimous that this group recommend that there be an urban Indian representative to the National Indian Health Board. The potential now exists for non-represented tribes to gain representative to the board... All in favor of that motion say "Aye" or raise your hands. Those opposed? (A divided vote was recorded).

Unidentified speaker: Are we on a time limit? It's 5:15, and this is vitally important.

Dr. Hammerschlog: I'm willing to stay.

Unidentified speaker: Your suggestion is that there be a representative, suggested representative, for landless Indians.

Dr. Hammerschlog: Landless Indians?

Unidentified speaker: Yes. There are many tribes that are aboriginal to their areas, but they do not have a land base. They have no land base, there are many Indians in California without a land base.

Dr. Hammerschlog: If we want to discuss that, it will take us at least until 6:00.

Unidentified speaker: We don't need to discuss it, we already know it.

Dr. Hammerschlog: O.K., would you like to call a question?

Unidentified speaker: Yes, question.

Dr. Hammerschlog: O.K., the question has been called. The National Indian Health Board have a representative from a landless Indian. Why don't you say it?

Unidentified speaker: This workshop, this group, recommends that the National Indian Health Board have a representative placed on the board for landless Indians.

Unidentified speaker: I'd like to hear the definition of a landless Indian.

Unidentified speaker: I just gave it to you. A landless Indian is an Indian who has no land base. He has trust status, but he has no land base.

Unidentified speaker: How can he have trust status without a land base?

Unidentified speaker: Very simple. I'll answer your question. In the fifties, when termination came into California, 33 small reservations and rancheros were terminated. There is now a lawsuit that was just won this year that the adults who signed did not have to do so, therefore it was illegal. They were misinformed. Our parents signed their names. So now, the wives and the children are back to trust status.

Dr. Hammerschlog: Does that clarify your question?

Unidentified speaker: Is that the legal definition?

Unidentified speaker: I just gave you a legal definition.

Dr. Hammerschlog: O.K., only the Indians of the east are landless. Well, not all. The Wampanoags, Naragansetts are landless. Now, do you want to make that as a motion? Those opposed?

Unidentified speaker: You're supposed to have a second to that first.

Unidentified speaker: I seconded it.

Dr. Hammerschlog: Shows you how aware I am. All those opposed? The vote is 8 to 3, abstentions 1. I wish we had more time to meet. It's been a delight to be with you. Thank you.

Ray Arkeketa: ...Number one, "why do health boards exist? Who wants to address themselves to that? Or maybe you want to take the first two subjects into consideration at the same time, "What is the function of health boards?"

Unidentified speaker: Well, I think that those two tie together, why have health boards, and how health boards function. What we are all interested in is providing better health services for our people. We can't do it as individuals, we can't do it as individual tribes. By having health boards, I think whether they be tribal boards or service unit boards or inter-tribal boards, you get this unity among the people. The way I look at it is perhaps the board provides better service to the people.

Ray Arkeketa: Then if we are united as a service unit board, we have more strength as an area board, and more strength as a national board.

Unidentified speaker: United boards would be more powerful, carry a bigger stick, than each board would individually.

Ray Arkeketa: There are some realities that always interfere with theory. Our area has 39 tribes, with almost well between one-third and one-half of the population of all the Indians in the United States, and we have the Papago with as powerful a vote as we have. These are some inequities with the national board that may, we know, hinder our efforts. We wonder why we have such a large population and why we just have one vote. They say they now have 12 members serving on NIHB, do they really need that many members? If they've got 12 then maybe we need more representation. Or maybe they need to restructure the areas in such a fashion that one tribe can't have one vote.

Unidentified speaker: This is a constant struggle we have with all programs.

Ray Arkeketa: Anybody have any other comments on these first two?

Unidentified speaker: I;m from the Shawnee Service Board and we don't have the "grass roots" input, and we have to improvise and play it by ear.

Ray Arkeketa: Somebody has got to take hold of the responsibility and act. I don't think that is going to be the "grass roots", although it sounds great in theory. You, as a health board person, know your area as well as anybody and better than most or you wouldn't be serving on the board.

Unidentified speaker: We are faced with this big problem of communication with the state of Oklahoma. We try to keep the different people informed, but it's almost an impossibility.

Unidentified speaker: I know that I get so much stuff from different organizations I belong to that I just can't possibly read everything.

Ray Arkeketa: What is the relationship with tribal councils and what is the relationship with Indian Health Service?

Unidentified speaker: Well, I can tell you about our tribal council members. Some of them seem to care less about it. They'don't even give a health report.

Ray Arkeketa: It might be that something that comes out of this would be this number 3: "What is the relationship with the tribe?" Because if you say tribal council, you limit it.

Unidentified speaker: We have a little different tribal organization. I am concerned not only with the tribal council, but also with an intertribal council, council for eight tribes. I think the relationship between the health boards, both the service unit board and the area board, and between our inter-tribal council is very good. I think the inter-tribal council is kept very well informed. I think on health activities of the area and service unit boards, we are kept up to date very well. There is another part to that question? "What is the relationship with Indian Health Service?"

Ray Arkeketa: Somebody earlier in the discussion brought up the relationship of the area director and board. We have 10 areas and we have 10 different philosophies, depending on who's running the place. While Sid is at one extreme we may be at another. I say maybe for the record.

Unidentified speaker: As an individual tribe I would have to say that our relationship is good with the area office.

Unidentified speaker: Why?

Unidentified speaker: I don't know why.

Unidentified speaker: You play Dixie in the proper tune or key. Maybe the rest of us should too. What I am trying to do is borrow a page out of your book. How is everything working so smoothly?

Unidentified speaker: We have, of course, the inter-tribal organization

which I think helps to do this, to unify the tribe in many areas. I don't think we always agree.

Unidentified speaker: I tell you what you've got to do, you've got to give and you've got to take.

Ray Arkeketa: What is the relationship with the area board and the Indian Health Service?

Unidentified speaker: I think there is too much censorship.

Unidentified speaker: Right now it isn't very good, let's be honest about it. P.L. 93-638 is Congress' mandate to the Indian Health Service. We have area directors who actively push towards tribal self-determination. I mean they lean over backwards. But there are cooperative people and then there are people who don't cooperate. What should it be? We are trying to make a policy statement. If we could make a policy statement of how we as tribal entities see boards it might eventually be different.

Ray Arkeketa: There is something to board tenure that you get through almost osmosis. I think Henry is a perfect example of that.

Unidentified speaker: It's a matter of knowing who to see about what.

Ray Arkeketa: And that just takes an awful lot of time. What is the relationship with Indian Health Service? Well, maybe that's not so important as what ought to be the relationship...

O.K., the next one: Do tribal health boards' structure dictate functions? What is the sanctioning mechanism? That's two in one.

Unidentified speaker: It's advisory.

Ray Arkeketa: Well, I think we all started out, all the areas started out with the term "advisory boards". I think that was more or less a term. Indian Health Service breaks down into human beings. They are either willing or unwilling.

Marlene Johnson & Larry Thomas, Chairpersons
Tribal & Urban Health Board Management

Larry Thomas: Do you have any specific recommendations as far as bettering relationships with the Indian Health Service?

Unidentified speaker: I will have to think about that. A better

relationship is needed, and I think the board needs more power on personnel matters. For example, we have doctors. I know Bethel had one who was supposed to be a good surgeon. Because they didn't have any surgical equipment except for emergency, he was a GP and he was uncomfortable acting as a GP. I suppose he didn't like looking at sore throats, headaches, and stomachaches. He was very unsatisfied with his job and he showed it. And the people didn't like that too much, so they went to work and got him transferred out. We need more power, we need to be able to change personnel around if we are not satisfied with them.

Larry Thomas: When you talk about "we" are you talking about health boards?

Unidentified speaker: Not necessarily health boards, but the people. The health board might know the person individually and get along with him great. The villagers are very soft spoken, they are very timid people. They don't like to hurt anyone's feelings. Unless you catch them in a bar someplace when they are halfcrocked and mad at the world they aren't going to tell you a thing...

Larry Thomas: ...Getting back really quickly to health board organizations, one thing that we failed to go into was how is membership made up on the health board or health committees? Is it appointed? Or is it elected?

Unidentified speaker: I might add that villagers are elected to the council by their village people.

Larry Thomas: We have another seven or ten minutes. We need to get into number three, the health board training needs. Could someone start us off on that:

Unidentified speaker: I feel that being on the health board is really important and it functions throughout the whole reservarion.

"Need for Health Board Training"

Marlene Johnson: You are saying you want on-going training?

Unidentified speaker: We have 19 board members right now. Out of the 19, about nine of them have been on the board more than two years. I have been in the organization going on two years now, and I've seen probably 30 different people there as alternates. It is hard for a board to sit down and try to conduct business and have to stop and explain to somebody what you are doing. I think they really do have a need for education of board members. We want somebody now that you

will trust for three years, so that we don't have this training problem every year. Our members are elected by the village council or IRA council.

Larry Thomas: So then one of the problems, you are saying, is continuity of membership?

Unidentified speaker: Right. With our health corporation, you can serve for a three year term and be appointed up to three terms. That is, you can serve nine years. If you appoint somebody for one year, and then next year appoint somebody else, and you only have four meetings a year, you take two of those meetings to try to break somebody in, and then they are gone. It should be an on-going training program, but it should be at least a week of good training for the board as a whole. Then the board can develop something that they can give to new people that come in.

Larry Thomas: Then you are recommending procedures that health boards go by for an incoming member. Does everyone who is on a health board or a health committee have tribal health directors? In other words, the board hires professionals to run the health board from the commity, someone who has been to college, or nursing training. She is talking about a tribal health director and her job duties are to take the suggestions of the tribal health board and put them into a feasible proposal.

Unidentified speaker: I was able to train the health board through tribal training money, but I had such limited funds I had to borrow money from Manpower, and I couldn't get consultants to really care about a training program.

Larry Thomas: First of all, why don't we find out in the audience, how many health boards are actually in action, as far as say, put together, organized and incorporated. Is everyone here a member of a health board or a health committee?

Marlene Johnson: Raise your hands.

Larry Thomas: Is anyone here representing a tribal council?

Unidentified speaker: I am also the director of a region.

Marlene Johnson: Number one: Why do health boards exist? Shall I read them all off? Why do health boards exist?

Unidentified speaker: Because the money was available.

Larry Thomas: Well, that's an honest answer.

Unidentified speaker: The reason for the health board in California is that four or five years ago there was no service at all, and this has been a means to reach Indian people in the rural isolated areas.

Larry Thomas: O.K., does anyone else have any other comments?

Unidentified speaker: In our area in northwestern Alaska, we found money that was available and created a health board. The fact that the villages didn't have any nurses, didn't have any doctors, caused problems in obtaining service. We did get a visit from a doctor twice a year and therefore, we created a health board, and got some health aides and got them trained.

"Health Board Functions"

Larry Thomas: Then what I am hearing you say is the health board is more or less an organized structure or vocal point for tribal groups to realte to different agencies. A board is a means to put together your tribal needs and express them to others.

Unidentified speaker: We created a health board to improve the health care among the Eskimos and the Alaskans. We are serving in an advisory capacity.

Larry Thomas: What do you see a health board doing?

Unidentified speaker: Well, I think one would be to prioritize health needs in each are.

Larry Thomas: Why would you prioritize the health needs?

Unidentified speaker: Well, that would be a feedback from the local level as to what they think their needs are. I think sometimes that what they think their needs are and what services can be provided are two different things.

Larry Thomas: What else?

Darryl Trigg: Well, in my area we definitely need satellite offices and nurse practitioners, so people don't have to travel so far.

Larry Thomas: Are you saying that your health board then would determine who should be provided services?

Darryl Trigg: In Alaska, we want to provide administrative and actual health services to the natives there.

Larry Thomas: The health board will be administering?

Darryl Trigg: Right. Right now in my area, for instance, we have four doctors to service about 7,550 to 8,000 people. Three of them are employed through health appropriations and one is employed by a local hospital.

Unidentified speaker: Could I ask a question? I don't know if I heard correctly or not, when Mrs. McGarvey was speaking on the 12 regions, did she say they set up profit as well as non-profit corporations?

Darryl Trigg: Right. We have the regional profit-making corporation which is created under the Land Claims Act and then we have a health corporation. We have an educational corporation and a lot of them are getting housing authority association. Well, our health corporations started in 1970. The educational arm has been funded under what we call rural CAP. They have been funded for a good 13 years.

Marlene Johnson: Does anyone else have any ideas, or could add to the functions of the health board as you see it?

Unidentified speaker: I think one of the things they should do is to provide health related information to the local people. I think that information delivery system falls down some place.

Marlene Johnson: Are there any others? Yes?

Unidentified speaker: What about communication on the higher level?

Larry Thomas: When he says higher level, does he mean from the tribal council to the people? In other words, they serve as a form of information to the people.

Unidentified speaker: I have one more function. They evaluate health care programs and health care delivery to determine the progress of the programs.

Larry Thomas: Does anyone have a system in your health board such as she is talking about which is an evaluation on quality of care?

Unidentified speaker: Our organization has been collecting data, but we don't have the actual results yet.

Larry Thomas: What is the relationship with tribal councils? These are specific questions I guess, they want answered, and I think they all tie in.

Unidentified speaker: The NIHB wanted us to break down into small groups, to ask some of these questions. One of the questions that keeps coming up is the relationship of a health board with the tribal councils. In other words, are health boards sanctioned in vour area? Do they have the responsibility and authority to contract? Can the board buy equipment or anything else? Do you have any problems with your tribal councils?

Unidentified speaker: We have no problems.

Unidentified speaker: I think that one of the problems some of our councils possibly face is that sometimes the health program becomes too independent of the tribal council. The council feels that they have lost control.

Larry Thomas: Does anyone have anything to add regarding relationships with tribal councils, or tribal governing bodies?

Unidentified speaker: I would like to make a comment on that. I think that once the health board gets incorporated, they are in competition with the tribal council because of the way contracts are worded from Indian Health Service or BIA, or even from 638.

Andrea Fastwolf, Chairperson
Tribal & Urban Health Board Management

Andrea Fastwolf: In this group, we are going to be talking about urban and tribal health boards management and under that we will be addressing four specific categories: (1) health board organization, (2) health board functions, (3) health board training needs, and (4) health board relationships. I am Andrea Fastwolf. I am the Executive Director of the Four State Indian Health Board which takes in North Dakota, South Dakota, Nebraska and Iowa. Can you introduce yourselves and the area you are representing?

Audience: I am Eunice Larabee, Aberdeen area, Four State Health Board; Alva Thompson, Community Health Representative, Cheyenne River Sioux Tribe; Milton Jefferson, observer, Director of the Inter-Tribal Council

of California Alcoholism Progra; Edna Ungudruk, Anchorage, Alaska, Independent Native Association, member of the Alaskan Native Health Board; Mrs. Rose Crow Flies High, Four State Health Board and tribal chairman; Celina Mosset, Community Health Represntative, Three Affiliated Tribes.

Andrea Fastwolf: First is health board organization. We will individually address the issue.

Edna Ungudruk: Lilly described our organization and our health board, and it is working really well. Everyone is represented. There are 12 members on the health board.

Andrea Fastwolf: How large an area do you cover?

Edna Ungudruk: The whole state.

Andrea Fastwolf: The whole state?

Edna Ungudruk: The state is divided into 12 regions under the Alaskan Native Land Claim Settlement Act, so in native concerns that is how people are represented. Each region selects one person to represent them on the Alaska Native Health Board.

Eunice Larabee: I think a good health board organization should be composed of people from each area on a reservation. I am from the reservation and I feel that each community on that reservation should be represented on the local reservation health board. The Four State board in the Aberdeen area has a representative and an alternate from each area. Our biggest problem is lack of communication. We have got to get across to our people at the local level that whatever health needs and concerns they have, they should tell the board members, and the board member goes to the meetings and informs the whole group.

Andrea Fastwolf: At the present time, what is the structure of the health board on the reservation that you represent?

Eunice Larabee: Our tribal council has three committees.

Rose Crow Flies High: I am from the same reservation that Eunice is on, and I might expand on that a little bit more. The Health, Education and Welfare Committee from the tirbe meets with the community health board once a month.

Audience: My name is Darrell Hostler and I'm from Northern California. I am the Chairman of the United Indian Health Service. I am Sophie

Thompson, and I am a social worker for Napa Area Indian Health Service.

Edna Ungudruk: In addition to the 12 regions there are seven service units within the Alaska area, and seven service unit boards.

Andrea Fastwolf: Anyone else want to make comments as to how their health board is organized?

Emmett St. Marie: We have a parent corporation and we have 16 projects, or 16 corporations. Each one has two members on the board, there are 32 board members elected in their own areas. Well, actually you start out with the local board which is in each area. Each area selects two board members to go to Sacramento from each project and we have 16 projects, which makes 32 board members. This is how the California Rural Indian Health Board is organized.

Darryl Trigg: We serve around 60,000 people. We do have another organization, an urban organization, but we are separate from them.

Rose Crow Flies High: Is the main headquarters known as California Rural Indian Health Board?

Emmett St. Marie: No, not the main headquarters. The central office is located in Sacramento, but the 16 projects are called CRIHB, California Rural Indian Health Board. Does that anwer your question?

Rose Crow Flies High: No. If you have a complaint, would you have to bring it to headquarters? We take our complaints to the tribal council and the service unit director.

Emmett St. Marie: No, actually we have a grievance committee.

Andrea Fastwolf: I think we are kind of getting ahead of ourselves. The second category is health board functions, is we could keep it all narrowed into perspective we would move along more smoothly. We have a new member in our group, sir, would you state your name and who you represent?

Gus Adams: I am Gus Adams and I am with the Indian Center in San Jose, a member of their counter-part California Indian Health Council.

Andrea Fastwolf: How do you feel health boards should be organized?

Celina Mosset: I don't see how we could come up with any concerns or recommendations. Each of us are from different areas and each area

has their own way of organizing their own health board that is comfortable with them.

Eunice Larabee: I think we all have similar concerns, for instance, communication. I would think in Alaska that would be one of your biggest problems.

Edna Ungudruk: I don't know how other health boards pay for travel to meetings for members, but out of our budget it is taken out of direct health care, the lump sum that is given to Alaska for direct health care. The Alaska Area Office takes $125,000 off the top from direct health care for health board functions. That is one of my concerns. While I think the health boards are important, so is direct health care. Congress ought to appropriate a set amount just for health boards instead of taking monies from direct health care.

Andrea Fastwolf: How are the boards funded?

Unidentified speaker: Yes, our health boards, three of them, are funded by the tribe.

Milton Jefferson: We don't have a tribal funding and we don't have the Indian Health Service funding. This year for the first time, we are receiving money from the state, about 2½ million dollars.

Gloria Manuel: No, we just receive a reimbursement from California Rural Indian Health Board. Don't some of the other health programs receive money from the county, local, state and tribal?

Milton Jefferson: We do receive our major funding from California Rural Indian Health Board and then we go to the regional medical program.

Andrea Fastwolf: Rose, you want to make any comments on how your health board receives its funding?

Rose Crow Flies High: Through the tribal funds.

Milton Jefferson: You get it directly from the tribal funds?

Rose Crow Flies High: Yes.

Milton Jefferson: Tribal operations?

Rose Crow Flies High: Yes.

Milton Jefferson: Then you receive a lot of money.

Rose Crow Flies High: No, we don't. We have our own tribal money.

Emmett St. Marie: I always hear about Indian Health Service funding, who in this group is from Indian Health Service?

Milton Jefferson: Our tribal funds come from tribal grazing land.

Emmett St. Marie: Who benefits from this, all this money we hear from Indian Health Service?

Eunice Larabee: The area board, the area boards are funded by them.

Alva Thompson: There are some funds for community development in South Dakota. They have a local board that is funded by Indian Health Service.

Andrea Fastwolf: Are there any in here that receive reimbursement from Title 19?

Unidentified speaker: Never heard of Title 19.

Andrea Fastwolf: Any type of third party reimbursements, Medicare, Medicaid or any of those, do you get reimbursed?

Eunice Larabee: I think this is something new that we are going to go into and for instance, the tribal councils are operating ambulance service. They provide ambulance service, Title 19 pays for ambulance service. Is anyone in this program getting reimbursed from the state? One, Cheyenne River in South Dakota, the tribe owns the hospital. Because of the isolation, a lot of non-Indians have come in there for hospitalization and they pay for their services to Indian Health Service. Indian Health Service sends it back to the U.S. Treasury, this amounts to something like $6 million. We hope we can recover it and the tribe plans to use it to remodel the hospital.

Andrea Fastwolf: I think we are looking for commonalities. I think one of the recommendations would be for funding for local health boards. I think this is one area where we all have something in common.

Eunice Larabee: I think we should recommend that the funding should be a line item for health board functions.

Andrea Fastwolf: Now would this be a part of the service unit directors budget, a line item right from that service unit director's budget?

Eunice Larabee: For the local board.

Andrea Fastwolf: The area board can't function unless it has a strong health board at the reservation level to keep communications open.

Eunice Larabee: We have a reluctance on the part of the service unit directors to have a health board. This should be specified in the service unit area.

Unidentified speaker: The problem is that the service unit directors have more authority than the health board committee for the tribal council.

Andrea Fastwolf: Funding seems to be one of the greatest problems. Should we move on to health board functions?

Unidentified speaker: That is number one, the health board has got to know the needs of the people on the local level. Also a health board has to be informed on resources.

Edna Ungudruk: The health board in Alaska is really strong in saying the hospital should change their system, so that they are serving better. The hospital has been very responsive. My recommendation is that the hospital or the area office should pay more attention to boards.

Andrea Fastwolf: We could tie this in as a recommendation for local service units to listen to the health boards.

Emmett St. Marie: I don't think a lot of the boards know what authority they do have.

Unidentified speaker: Well, one of the problems is that time schedules are prepared and the budget is written as if the board didn't exist.

Andrea Fastwolf: What type of training would I need as a board member?

Eunice Larabee: We have to have this training in order to make more effective decisions.

Andrea Fastwolf: Can you identify any type of training, for example, management or budgeting?

Unidentified speaker: Policies or procedures of the Indian Health Service. In California, actually, what they really need is information on the authority of the board.

Andrea Fastwolf: That would be management.

Unidentified speaker: I think it is vital that the board should learn about 638 because they can start contracting for Indian Health Service health care and start working or running their own health board.

Unidentified speaker: One of the real important things that health boards need to know is how to go after funding and how to lobby.

Andrea Fastwolf: I want to thank all of you for taking a real active part. Thank you.

Thursday, July 1, 1976
National Health Insurance; Conference Evaulation; Wendell Chino, Chairman, Mescalero Apache Tribe, "The Future of Indian Health"; & Conference Wrap-Up

George Platero: Good morning. We have some distinguished guests here. First, I'd like to present Sandy Nichols, one of the staff of the National Indian Health Board. Her presentation will be on the National Health Insurance.

Sandra Nichols: This morning we'll be presenting the position that the interim group on National Health Insurance came up with. National Health Insurance is not a reality at this time, but the National Indian Health Board feels that it is very important for Indian people to have input into this legislation before any bills are passed and that's the purpose of the NHI portion of the conference. On Tuesday afternoon, the NHI conference broke into several groups which included consensus issues on NHI, the unresolved issues, legislative strategy and urban Indians and NHI. Everyone who was in these groups was represented in the NHI Interim group. So, everyone who participated in the groups has his or her say in the final position or revised NHI position that we came up with. We divided the final position into five sections. The first one to speak will be Ellouise De Groat on the legislative strategy and the follow-up work.

Ellouise De Groat: To begin with, I think the purpose of this conference was as Indian leaders and as Indian representatives to support some kind of a position statement on the NHI that would be taken to wherever the lawmaking bodies are. As a result, we came up with a legal strategy. We hope that this conference will endorse the function of a working group to address the issues and problems and concerns in regards to the NHI. We have decided that because of the different issues which cannot be resolved at this conference, it will take a group of people who have time to talk and to develop a very specific format for our Indian NHI position. We want to let other people know what the American Indians' thoughts and feelings are.

The NHI Core Group will consist of representatives from the National Indian organizations, urban Indian groups, the federally and the unfederally recognized tribes, and in addition any other persons or groups that want to share any problems of all American Indians and Alaskan natives in regards to the NHI. The porpsed group is as follows: representation from the National Indian Health Board, the National Tribal Chairman's Association, the National Congress of American Indians, American Urban Indian Health Care Association, the Association of American Indian Physicians, unfederally recognized tribes, Community Health Representatives.

These are just some of the recommendations that were made. There may be others that we have not listed, if there are any others please request membership in the group. Primary responsibility for the ongoing coordination and effectiveness of this working group will lie with the National Indian Health Board. In addition to the function of the

Core Group, the following action will be taken to insure that the National Health Insurance Position is disseminated to key persons at local and national levels. The National Tribal Chairman's Association will contact its membership. The National Congress of American Indians will do the same and on down the line. This core group will be working with the House Ways and Means Committee, the Senate Finance committee and any other important congressional committees at a national level. We must also urge that each tribe contact their congressional delegation once this consensus position has been arrived at.

Sandra Nichols: Thank you, Ellouise. And now, Dan Press will speak on the revised Position Benefit Package.

Dan Press: Thank you, Sandy. On Tuesday, when we presented the tentative position there were several unresolved issues and principles that we said would be discussed in the individual small group sessions. People have made the interim group put this all together and cam up with a revised position. The panel will go over each of these changes.

"Participants 'Want Nothing to do with NHI'"

The first unresolved issue was how the benefits from NHI flow into IHS, or what relationship Indians should have with the NHI program. The consensus that came out of the different working groups was a very clear feeling that Indians really should have nothing to do with NHI. Indians have their own health system, their own method of financing it, it's a system that they feel strongly about continuing. They are concerned that NHI possibly will weaken that system leading to its eventual erosion. They don't want to see financing or the delivery of health services to Indian divided, with one part being done by IHS and another part being done by NHI. They felt that the most important issue would be to separate the IHS from the NHI program, a type of separate but equal philosophy. Indians should be entitled to the same benefits other Americans can receive from NHI but rather than getting those benefits through NHI, they should be entitled to get those benefits through their own IHS. The finances should come directly from the Senate and House Committees to finance the IHS rather than have the money come from the NHI.

So one major change in the position is that the Indian National Health Insurance position be that of separate but equal. IHS tribal programs should be retained, strengthened, be given equal benefits and equal rights and should not directly participate in any way with NHI.

Sandra Nichols: Thank you, Dan. O.K., now Dr. Jim Felsen will speak on the taxation issues.

"Taxes 'Already Paid'"

Dr. Felsen: The interim group considered the other unresolved issue that the conference participants have taken on taxes. In the small groups there was a political realism that there might have to be a considerable amount of compromising done with taxes based upon type of tax. I think there was a unanimous feeling that the position essentially ought to be that there are no taxes or premiums paid by the Indian people. The taxes have already been paid by Indians for hundreds of years. It was the consensus of the position that there must be no taxes, premiums, co-payments or any other charges imposed on Indian people by NHI.

Sandra Nichols: Hickory Starr will speak on self-determination and tribal sovereignty.

"Self-Determination"

Hickory Starr: I think this is probably the most important part of the total discussion. We were very emphatic that we did not want any erosion of health services that are presently available through IHS. If anything, we wanted them strengthened. As it is written, the principle that we have states that Indian tribal governments, urban Indian health boards, as well as non-reservation Indian tribes must be recognized as the appropriate entity for administering NHI. NHI must not be under state government's authority. Nor should NHI give too much authority to IHS. But, we felt that Indian people should have the right to set standards as far as our expectations are concerned. Each tribe should establish a code with minimum standards. Tribal councils, urban Indian health boards, tribal authorities will designate what providers of services will be and that those tribal authorities will be responsible for following up and insuring that these required standards are met.

As urban Indians, there were two basic major concerns. One: exclusion. We don't want to be left out. If you've read all the information that was passed out the other day, it's very clear the IHS funding provides service for 70% of the population on reservations or near reservations at the present time. That means that 30% of the people on or near reservations are not able to get adequate care. That's nearly half of the total Indian population that reside in urban areas who are completely excluded from any of the IHS services. And this population is the one we're concerned about. Urban Indian health boards are now partially funded by IHS but most of them are having to rely on funds from other sources to operate health care programs. As we look to the future we're going to have to depend on sources from other federal programs and private sources or whatever source may be there for funding.

Indian people in cities will still recognize private governments as

their lind to the special relationship they have with the federal government. They don't want this disturbed in any way. Regardless of what people in other areas of the country may feel about them, they still consider themselves a part of their tribe. Because they have moved to the cities, they have more or less been isolated and excluded from any types of programs. As urban Indians we, too, voice concern that the tribes have over state control because at this time, we do not have access to federal programs through the state and we want to be able to get direct access.

One final recommendation, we purposely avoided in all of our discussion any kin of an attempt to define who an Indian is. But I think as time goes by that's going to become more and more of an issue as far as NHI is concerned. We're assuming that NHI is going to be. That problem has got to be resolved. Some means of identifying or defining who an Indian is has got to be developed. So there's going to be a tremendous amount of work to be done in this area.

Sandra Nichols: Thanks, Hickory. We'd like to throw the floor open for discussion and questions now.

Unidentified speaker: I'm concerned that this will affect the tribes that do not have any health service facilities, especially in Wisconsin and Michigan, I think there is just contract care. We are only getting about 30% of the money that is really needed and we have to immediately set priorities as to hospital bills and things like this. If it's left up to IHS, as it has been, and we have to practically beg for every penny that we are getting, I don't think there would be an improvement for the 17 tribes in that area at all.

Hickory Starr: The position that is being recognized by the interim group is that Indians get the same rights as other Americans, but we aren't going to get them under NHI because we get it through IHS and with that, we have the Guaranteed Benefit Package. Every person who needs the service has coverage and the legislation would say here is the benefit package, to cover all in-patient, all out-patient, all well-child clinics and so on. At any time that Indians need those services the money has to be there. It's a legal contract and that person has a legal right to get these services.

We're proposing that IHS be required to adopt a similar benefit package and that Congress commit itself to provide full funding for that benefit package. Everyone else is going to have 100% full funding and IHS should have the same thing. I think there are some real inequities between the tribes that have direct care versus tribes that are forced to use only contract care. That issue is not addressed by the NHI position, I think it's a separate issue and a very important issue. I think it's one that the health board tries not to take on because groups that just get contract care get a much smaller amount of services.

Unidentified speaker: I'd like to know what mechanism has been developed or thought about to get this information that's been gathered together

here to the people in the local areas. I think one of the most difficult aspects of this conference is that many people who came here knew very little about this issue. I know that it would be helpful to the Indian community to have inforamtion about the original six principles together with those three funding requests.

Unidentified speaker: All those who register for this conference will receive a copy of the final position. Also the purpose of the core group is to establish who will be sending out the information and how it will be sent out.

Ellouise De Groat: How do we distribute this information to the grass roots levels? I feel that the responsibility lies with the Indian people. Maybe we better take another look at who we represent. And who represents us at the large conference. How is this information being disseminated to the local people? That, to me, is the responsibility of the representatives that come to these conferences, taking back as much information to the people as possible, that to me is what representation means...

Nicky Solomon: Sisters and brothers, here in this auditorium, I'm Nicky Solomon; I'm your CHR representative and I feel that we cannot drop this issue here. We must continue. What about Public Law 93-641? We have an opportunity here and now to have input into whatever Congress sees fit to put into National Health Insurance. And I certainly would endorse the continuation of this group that was proposed by the panelists, provided too, that they came out of this conference of small group discussions. And all I've heard about 93-641 is complaints. You know, where are Indians going to be? Where do we fit into that? And that is past. But now we have an opportunity.

We know that there were 21 bills before Congress that involved National Health Insurance last year and you can bet your lives that in the next three or four years we're going to have some kind of National Health Insurance. We have the opportunity now and you're asking for grass roots input; you know, what better mechanism do you have than the CHR programs throughout Indian country? That's where -- I haven't seen that many CHR's here today at this conference. But that's where the grass roots are. And I'm certainly endorsing the fact that CHR's are going to be included in this group to carry on.

Unidentified speaker: My general question is, is IHS considering becoming a third party claim type system and what is the guideline or what is their outline as to receiving reimbursements as a third party? And if so, what is the problem input with that?

Dr. Felsen: Yes, at the present time, in the Indian Health Care Improvement Act there is a provision for IHS to be reimbursed as a third party. The different committees of Congress, not only the Interior Committee, Ways and Means and the Health Committee, have all acted favorably upon IHS being able to be reimbursed by federal third-party programs.

And, going a step further into that, initially, the money received from third-parties is supposed to go to improve the standards of Indian health facilities so that they can be brought up to national standards regarding the safety, the facilities structure, staff, etc.

Almost everybody supported reimbursing IHS as a third party with the exception of the administration and they even backed down and supported it. Only, they wanted it to be counted as a direct approriation. What you come up with now -- like at this conference or from listening to the people -- is that they really don't want reimbursement in that sense, i.e., case-by-case type reimbursement. They want equity, at least the basic benefit package, plus more. Now I think that idea has been communicated to the administration for about a year or a year and a half and theybasically support. The problem I have with it is that it's easy to support it as a policy issue but, when it comes for the committee to put up the cash, the appropriations committees, I don't know if they will.

However, the administration sort of agreed that if we can get the money, it doesn't make sense to go through third-party reimbursement. So, right now IHS is obviously supporting the Indian Health Care Improvement Act and they're supporting that provision of it. But I think what we're really supporting is more money for Indian programs, not necessarily whether it goes through a reimbursement process or whether it just be directly adequate funds appropriated.

Andrea Fastwolf: My name is Andrea Fastwolf. I'm the Executive Director of the Four State Indian Health Board in Aberdeen, S.D. and I don't have a question, but I do want to comment on something that I seem to be hearing here. That is the fact that there seems to be a lack of communication in regards to NHI from the national level to the local area. I am aware of the fact that there is a lot of information coming out of the NIHB office in regards to NHI. This is sent to our local health board offices and it is our responsibility to get this information to the people who we represent and if this inforamtion isn't getting to the right people we take a look at the people who we have charged with the responsibility of getting this information to you and have them respond as to why you are not getting that information. Thank you.

Sandra Nichols: ...At this time we would like to receive a general endorsement on the position stated today from this conference and on the continuation and formation of the Core Group to keep on working on these issues on NHI. If you like to endorse the position, we would like for you to stand up at this time.

George Platero: If you wish to endorse the position that was brought out this morning from the small group and from the discussion we would like to have you stand up.

Unidentified speaker: Madame Chairman, would you please state the second part of the NHI position?

Sandra Nichols: The second part is that there shall be a Core Group made up of all the major Indian organizations and any other concerned interested Indians who will take this position, then develop it, polish it up and see that the people in Congress are developing an Indian section and pushing it through and that they will be aware of the Indian position and will make sure that the legislation will adequately reflect it.

George Platero: Now we would like to ask for your endorsement by standing up.

Unidentified speaker: Small Tribes Organizations from Western Washington officially will the adoption position made.

Unidentified speaker: Second.

Unidentified speaker: Third.

George Platero: Would you like to stand if you're in favor? I wish at this time to have it stated there is a motion on the floor that we will have an endorsement, a general endorsement of the position. There is a motion on the floor to endorse this position and all in favor please stand up.

Sandra Nichols: You may sit dow now, the motion passed.

Howard Tommie: Ladies and Gentlemen, at this time we would like to introduce a gentleman that has been in the Indian business for quite some time and has a special place in his heart as far as concern for Indian people. He has worked within his own tribe for many years and he is still there working for the betterment of his tribe and all aspects of Indian life. Being a national figure is not an easy task but he has taken it upon himself to be the Chairman of the National Tribal Chairman's Association... Mr. Wendell Chino.

KEYNOTE SPEAKER Wendell Chino, chairman of the Mescalero Apache Tribe and also of the National Tribal Chairman's Association.

Wendell Chino: Thank you very much. My subject is suppose to be the future of Indian health... My first point that I would like to talk about is the future of Indian tribes. At the risk of repeating myself, for in the last few months I have traveled and criss-crossed this country speaking to different groups, I have read this article from the United Tribe News from North Dakota and I would like to repeat it again. I think that this particular statement is worth repeating and worth making the Indian people aware of.

I quote from the paper, "Surely no one can seriously believe that the Indian reservation is going to be a permanent part of the American scene and it is difficult to see why anyone would want it to be", testified Ralph Gillan, Assistant Attorney General of Nebraska. Let me just read that part again, "Surely no one can seriously believe that the Indian reservation is going to be a permanent part of the American scene and it is difficult to see why anyone would want it to be."

We could not understand why Indian reservations should continue and would continueto be a part of the American scene. You and I have no apologies to make for Indian reservations, the Indian reservations represent nothing more than a very, very small portion left to the American Indian who was at one time the greatest landlord in this country. In addition to this particular statement, five states, five western states, organized to opposed tribal sovereignty and tribal jurisdiction. Very rapidly, that organization picked up an additional state and soon it became an 11 state organization. The latest count numbers it at 14 states.

The objective of the organization is that tribal sovereignty and tribal jurisdiction must be diminished and tribal governments should not exercise their sovereignty and their jurisdiction beyond the confines of their present exterior value. The same group also is interested in taking Indian water at whatever cost, so we have these sentiments and these groups to deal with. In addition to these groups, of course, there are also the anti-Indian federal groups such as the Bureau of Land Management and the Corps of Engineers.

All of these people certainly do not understand, neither do they appreicate the services rendered to Indian people. You and I can sit here and talk about health services, special services to our people but let us remind ourselves that if these groups prevail, there will be no Indian lands, no Indian water, no Indian people and consequently, no sovereignty, no jurisdiction.

Without these resources we're nothing and what are we doing to assure that they continue in the ownership of the Indian people? The future of the Indian tribe must be insured, because there are groups in this country that are interested in seeing that the Indians are removed from the American scene.

Next point that I want to make concerns special services. I would like to read a portion of a paper form the Atlanta office dated April 19, 1976,

just over two and a half months ago. The subject is the organization for Indian affairs and the individuals that are involved in writing this paper in the Office of Management and Budget. What they are saying is that let's get out of the Indian business, talk about National Health Insurance and the health services provided to our people, education, law and order, social services.

In different parts of the country, people are wondering why should an Indian have these special services? Eventually Indian services can be fragmented and they can be lost in the jungle of services provided to all citizens. So, we need to get back to these special services rather than being apologetic about it. We should remind ourselves that the Constitutuion of the United States made the Indian people a very special group of people. When the framers of the Constitution were writing the Constitution of the United States, they said, Congress shall have power to regulate trading and commerce with foreign nationals, with the various states and with Indian tribes. And this has established that unique federal Indian relationship.

And I say to you that the Indian people have a constitutional relationship with the federal government and as a result of this special relationship, we have these special services. Are we going to subordinate these services by health insurance which comes through the states to us? I think this must be stopped, the way some of these things are leading. I got this from the Wall Street Journal. Congress appropriated two and a half billion dollars to maintain the state of Israel. Two and a half billion dollars. Do you know what that is costing you and me as taxpayers? Six million eight hundred and forty-nine thousand, three hundred and fifteen dollars per day. Six million dollards a day to maintain the state of Israel. And all we're saying is that the American Indians are also entitled to special services. We're not questioning the funding of the state of Israel. But, I think American citizens have a right to question the priority. The priority of the United States Congress should be that the needs here at home and particularly among the Indian people are so great.

Now to the point for which I was invited, the future of Indian health services. As I said in the beginning it is pointless to talk about the future of Indian health services unless these two other points remain intact. Indian tribes and Indian people must be given the right to perpetuate themselves and be a part of the American scene. We have no intention of helping to perfect the land, the water and our people. I think the time has come for the right people to be appointed to Indian health services. We must insure that the National Indian Health Board has established priorities. They're having a hard time getting people to move at the Washington level as well as at the area level.

Number two: I think that we need to establish necessity of our health care and in fact, total need of our Indian people. I believe that every area health committee ought to go to their respective area on their respective reservation and in fact determine what the needs are. Once we have made these assessments, then, I think that we ought to determine when these certain needs can be solved and certain goals can be achieved. If we set no time limit they will continue to say perhaps next year will be time to appropriate enough money to take care of the needs. I think the time has come for us to come to grips with these needs. Not only do we need assessments of our health needs, I think we also need to accelerate services.

I think we should also respond to the inter-department communication that has been put out this month. In that communication there is a section dealing with Indians. Do you like it or do you not? I think it is up to us to take a look at this communication and respond to it because it has a date of July 19, 1976, when they would like to have your response. We need to appoint people, we need to assess, we need to accelerate and I think we need to accomplish a few things. And I think that the education of the para-professional and professional Indian health people is long overdue. This is why I think that this health board and this conference ought to concentrate on the Indian Health Care Improvement Act, let's get behind it.

I think we need also the application of the local people in preventive medicine for our local people at the grass roots level. And as far as I am concerned I think the key to Indian health is preventive medicine.

Oh, my friends, if you have the Indian's pride in our Indian people, let's be aware of it, let's get to the facts, let's reform. When you come back as a representative of your tribe, when you come back as a representative of a particular group of Indians in some of the urban areas, say "I know that my tribe, my group will be better because I was at the conference and I was able to enjoy myself because I made an input and I received an input." Let us all be concerned about improving Indian life. Thank you very much.

Thursday, July 1, 1976
Joint NIHB & All Indian Health Boards Meeting, Resolutions.

Howard Tommie: We would like to welcome you to the final session of the conference. Of course, whatever you have said and whatever recommendations that you have made to the board during this conference will be taken into consideration in the part of the system that is responsible in an advisory capacity for the advice of the IHS. I want to get right to the areas of the National Indian Health Board and what I understand that the people who are attending this conference are concerned about. What is the National Indian Health Board? I think we have placed so much emphasis on issues that we have completely overlooked the fact that some people might be interested in what the NIHB is all about and what their function is and how the board is formulated. We have a task to do and as we see that task, it is to inform the Indian people and the area/local health boards throughout the United States of the functions of the National Indian Health Board...

Our board meets four times a year in every area of the country. The purpose is to bring resource people with us so they can meet with local people. We have a budget in excess of almost $100,000. We have two special meetings on particular legislation that needs to be reviewed by the National Indian Health Board andthen we have two special meetings allowed by the board to meet on a specific issue. I hope I am giving you some useful information.

From this conference we have found out that there has to be a strong effort to get the information out to the Indian community. We realize the fact that there has to be a lot of information distributed as far

as the National Indian Health Board is concerned. Unless there is someone else who wants to clarify what has been said we will proceed with answering some questions. I am from USET area and I represent the United Southeastern Tribes. I am chairman of my tribe, my name is Howard Tommie. If you all would like to use the mike, we will be glad to listen to questions or comments.

Tommy Reno: My name is Tommy Reno, Chairman of the Northern Valley Indian Health Board, member of the California Rural Indian Health Board. The first question I would like to ask is how was this board picked?

Howard Tommie: In my area there was an opening when the board was formed in 1969 and they wanted a representative from USET so the tribe has a board and they picked who they would like to represent them on the NIHB. They picked me and I think, this is the process used in each area by each board.

Tommy Reno: Second question I would like to ask is I know we have a fine National Indian Health Board, they really represent a lot of people, but is this board truly representing people that are in the urban area and also off-reservation people?

Chief Tanyan: I am Chief Tanyan, I represent Oklahoma, there are 38 tribes represented on my area board and so I'm representing about 155,000 people. So that part of the off-reservation Indians have been represented here today.

Howard Tommie: I personally cannot sit up here and say that I represent the urban Indians because I have never been an urban Indian, I have never lived in an urban area and I don't know the problems of urban people but this board has always endorsed urban problems that have been brought to the board.

We're going on record to say that there has never been a time in the past that I can think of that NIHB has ever turned down any urban resolution that has been presented to the board. I don't know whether we are answering the question or not but that is the way I feel and I might be speaking on behalf of the board.

Unidentified speaker: I understand that this is an organization that has constitution and by-laws, and according to the constitution and by-laws, there should be a way that additional membership on the board can be determined. The first recommendation I have is that we should have a member on this board from the urban Indians. The other one I feel should be a board member from the off-reservation people. Those are two recommendations I would like to make to the board, of course, somewhere along the line maybe you can think about it.

Howard Tommie: That recommendation will be taken into consideration. I

understand that there has been some discussion at some of the workshops here about this and even the reservation people are asking for additional membership to this board and we are going to look into it. I might explain one thing that this board is really concerned about as far as additional membership is concerned. The concept now is that there are 12 areas in the United States and each one of them has one representative to the board. This board serves only in an advisory capacity, we are not a policy making board.

That is not to say that we are not considering any additional board members. These are the main concerns and we can overcome these concerns. I think we will have adequate representation on this board. I just wanted to bring that fact out for the benefit of the people that might have questions concerning the board's membership.

Tom Lone Eagle: I am Tom Lone Eagle with Tri-County Indian Health, I think what you are saying is well and good but it is a form of cop-out. I live off the reservation, I have never lived on one but I serve on the Valley Indian Housing Authroity Board, I am on the health board, I am chairman of our water district, but there is nobody to represent me. I have never been able to utilize any of the services that are offered Indians and I feel that you cannot classify the urban or off-reservation Indian with others in the light that you have. It is not that we are trying to represent or we want somebody to represent us specifically as another addition to the 12 members that are sitting on the board, I think we are in a completely different light and I feel there are other Indians that are in the same position that I am that have never been able to utilize the services offered to Indians. The only way that we can be heard is to have representatives that have lived off the reservation for the biggest share of their life or all of their life and to see that the 12 people sitting on that board up there are aware of what our problems really are. If you have never lived off the reservation how can you make the decision that is good for me when you don't know what my needs are?

Howard Tommie: I don't know enough about your problems to say well this is the way I think you ought to run your program. That's very hard for me to do. That's not in answer to your question but this is an opinion.

Timm Williams: First I would like to compliment the National Indian Health Board for bringing the conference to California. My personal feeling about the representation of the board in regard to landless Indians, Indians who have never been recognized by the government, and full tribes who have never been recognized by the government is that unless those divisions have somebody sitting on that board level I think that that would be a secondary issue with that board.

I am not back on the reservation again, but nevertheless, I can see where the people who don't have the recognized tribe by the government, the legal representation that is required by the Bureau of Indian Affairs or by the Department of Interior are being left out.

Howard Tommie: Thank you, Timm. Timm is a former member of the NIHB and shared these concerns when he was serving on the board. I don't want to set up a big organization to confuse the issue, that is one of my main concerns.

Dr. Rabeau: When NIHB was created we had no program dictated by Congress for either urban Indians or landless Indians, with the exception of the CRIHB program in California. That is why the membership was constituted because it represents each administrative region of the IHS. It has been four years now since this has been constituted and during this time Congress has started to change its policy. They now specifically mandate a limited amount of urban projects which seem to increase every year. So, times have changed but the constitution of the board hasn't. Now maybe it is the time where NIHB says we need to have an additional member on the board to represent the urban and landless Indians.

But, the primary function of the board is to be an advisory group, to advise the IHS and Congress. At the time the NIHB started we were forbidden by law, by regulations, and above all by appropriation from Congress to do anything outside of providing care to what they considered was traditional Indian land. Now since then they have quite an urban problem, so I think probably the time is right that the board may want to consider recommending to Dr. Johnson that there be an additional member to represent the urban landless Indians. Thank you.

Howard Tommie: Dr. Rabeau, I know you personally, but you may wnat to clarify your status.

Nicky Solomon: He is Director of the Office of Research and Development in Tucson and past director of the IHS and also the godfather to the CHR program...

Unidentified speaker: ...Right now, I'd like a show of hands of the board members up there that would be against having another representative representing the off-reservation, non land-based Indians.

Howard Tommie: Are you asking the board to show hands?

Unidentified speaker: Yes, I am.

Perry Sundust: I don't think that I can commit myself to any action on the board because I represent the Phoenix area and I have to consult with my area board and local grass roots people in the service unit. I don't think that I can make any personal vote on this action. It is up to my local board in my area, my service unit board.

Unidentified speaker: Well, I am glad that you made your stand in that way, because you are telling me that NIHB does not represent the Indian

people. You represent a portion of them, I would say less than half. So this board of health is actually worthless. I feel that the work that I do for my people is very worthwhile and I would like to feel that I am a part of them, and not good to be treated separately because I don't live on the reservation.

Joe Benitez: I would like to respond to that. We have a mechanism in California which is called the California Rural Indian Health Board and several years ago this board passed a resolution to leave the board representation to the National Indian Health Board as it was.

Unidentified speaker: Joe, I recognize what you're saying and I think that the job that is being done in California is really super fantastic. But I am talking for all 50 states and all of our people throughout the nation. I realize that California's problems are quite different from most others, but I do feel that the board object should be not to have to go to any tribe or anybody else. The reason you're sitting up there as an individual representing Indians throughout the United States or you should state the fact that you only represent recognized Indians and recognized tribes, or certain facets of the Indian community. If this is true, then I don't have any business being here representing somebody that can't represent me. Do you know what I mean? It's a question that is asked by many people, and I wonder how many people the board is representing: What percentage of the Indians in the United States do you really represent? If you only represent people from your tribes then you are not representing the Indians, you are representing a minority of the Indians.

Unidentified speaker: I would like to know just exactly how many Indian people do you represent on the National Indian Health Board.

Walter Woods: We have something like five tribes: Sac and Fox, Omaha, Winnebago, the Sioux Indians and the Chippewas, and we number about 70,000 in a four state area, North and South Dakota, Iowa and Nebraska. Does that answer your question? We have 70,000 in our area.

Elwood Saganey: I am from the Navajo reservation and I represent close to 60,000.

Chief Tanyan: I represent Kansas and Oklahoma, and that's something between 38 and 40 tribes, and i can't name all of them, but they do number 38 to 40 tribes.

Perry Sundust: I represent the three states of Nevada, Arizona and Utah, population 55,000.

George Platero: I represent the state of New Mexico and a portion of Colorado which is, in round figures, about 40,000.

Howard Tommie: I represent the states of Florida, Mississippi, New York and North Carolina, and Louisiana, numbering in the neighborhood of about 30,000 people.

Joe Benitez: I am the California representative to the board, and we have approximately 45,000 that we could testify that we really serve. It is probably erroneous, but that is the figure that we are using: 45,000.

Dennis Tiepelman: I represent Alaska, and I estimate that there are approximately 65,000.

Donald LaPointe: The three states of Michigan, Wisconsin and Minnesota.

Lorna Patricio: I represent the Papago tribe of Arizona with a population of about 14,000.

Ada White: In the Billings area we have an approximate enrollment of 30,000.

Unidentified speaker: The urban representation question should be on the agenda for the next NIHB meeting. Thank you.

Unidentified speaker: I want to ask the gentleman from South Dakota how far the Aberdeen area extends responsibility for Indians who are tribal members of the reservation, but who are just off reservations?

Walter Woods: (Begins response...)

Continued from the floor: You have the Oglala, you have the Sinte Gleska, you have the Cheyenne River Indians, you have all the Little Sioux out there, and many of them are in the California area and many of them need the health care, extended off the reservation health care.

Walter Woods: Now, this seems to be a problem...

Continued from the floor: I think that this is an issue that should be dealt with. Can I have your answer?

Walter Woods: Yes, are you done now? O.K. We will be glad to respond to that. We do have that problem. What they usually do, they go to the local hospital and get services and send us the bill. Well, say, in my area, I know what I'm talking about in South Dakota. Those bills come to our hospital, and these issues are taken up with the service

unit director. In some areas we do try to find out if they are eligible for any other programs besides just what they have there, and we do try to help these people out in some way. But you know, most of your service unit hospitals only have so much money to spend. Consequently, what happens is that priorities are set up and we try to serve the people in our own area. However, we only have so much money and sometimes we are not able to afford these services that are required. Our budget this year, of course, went into the red by trying to help other people, in other areas. We don't try to trun services away, but if they would contact the area that they are from, usually that are will try to help them out in some way. I don't know if you have done this or not.

Howard Tommie: Thank you. Would someone make a motion from the floor to go on record in the general assembly for the National Indian Health Board to research the possibility of including off reservation membership with the National Indian Health Board. That would be a mandate we would have to follow.

Unidentified speaker: I so move.

Howard Tommie: We have a motion.

Unidentified speaker: I move second.

Howard Tommie: Thank you... All those in favor say "aye", those opposed say "no". The motion is passed. I will end the discussion on the NIHB and go on to Resolutions. Dennis Tiepelman is chairman of our Resolutions Committee...

Dennis Tiepelman: We had a total of six resolutions introduced and reviewed them in committee. We referred two resolutions to the National Health Insurance Task Force. The other four represent certain issues that different areas of the United States have presented. We will just briefly mention the resolutions to inform you of the issues and any objections you have may be presented as well. I'll just read them off to you and briefly explain or summarize them.

The first resolution that we have is supporting the Eastern Band of Cherokee Indians in their efforts to obtain federal funding for the construction of a new hospital at Cherokee, N.C. It shall therefore now be resolved that the National Indian Health Board hereby supports the Eastern Band of Cherokee Indians in their effort to obtain the necessary funds for the construction of a new hospital which will serve the needs of the Indian people.

Another resolution that has been introduced is asking for total benefits for hiring professionals in the local native health corporation in Alaska. Therefore be it resolved the National Indian Health Board shall work with Alaska Area Native Health Board in obtaining funds and regulations providing employees of the Alaskan Native Health

Corporation's salaries and benefits comparable to Indian Health Service, Alaska Area Health Service and other business enterprises in Alaska.

Another resolution requests that it shall therefore be resolved that the National Indian Health Board establish a subcommittee entitled U.S. Schools of Public Indian Health to address the immediate training needs on the undergraduate, graduate and post graduate levels for Indian people seeking careers in public health.

The fourth resolution that we have here is a resolution requesting that solid waste control systems in the Alaska area and more specifically in the Bethel service unit are explored. Therefore be it resolved that the National Indian Health Board assist the people of the Bethel service unit area to acquire assistance from appropriate governmental agencies to develop, implement and evaluate the means to control solid waste by instituting pilot projects and advancing technology and awareness to provide a more healthful environment. These are the resolutions that have been presented at this time and if there is anybody out there that has a specific concern or wish to add to these or wants further clarification can request the clarification now. At a national conference such as this, I would leave it up to the board to see if there is something that has to be clarified from the areas. Are there questions...?

Alice Neakok: Yes, sir, you were speaking on the water and sanitation resolution. I represent the North Slope area and I still represent all of Alaska and we need water and sanitation up in the northern part of Alaska, too.

Dennis Tiepelman: Okay, in the resolution it did mention the Alaska area and more specifically brought out the point -

(Interruption from the floor) That is not what I wanted, I want the service area to know it in Alaska.

Dennis Tiepelman: Are there other questions from the floor at this time, any more clarification. In hopes to expedite this we might just have the floor accept the resolutions as introduced.

Unidentified speaker: I move that the resolutions be adopted.

Dennis Tiepelman: A motion has been made to accept the resolutions as introduced. A second. Is there any more discussion on this? All those in favor of the resolutions to be accepted as the convention vote signify by saying "aye", opposed signify by saying "no". Let the record show that the convention has accepted the four resolutions at this First Annual Convention.

Howard Tommie: I would like to bring this conference to a close now.

There were two things that we were a little bit concerned about. We were concerned regarding the amount of participation. I think the participation has been great as far as our evaluation is concerned today. One complaint from the participatnts was that they did not have adequate information. We try to get as much resource personnel as possible to bring these facts out for you. We should try to work together. As the chairman of the National Indian Health Board, I want to thank everyone that has come back here this afternoon. I think that it has come about and that we can have a clear understanding that people are interested in attending our conference concerning health.

We felt like that there was a need for one and the NIHB has tried to bring health issues to you in this conference. I would like to thank Joe Benitez again for hosting the First Indian/Alaska Native Health Conference and doing a very good job of it. On behalf of the NIHB, I would like to thank everyone for their participation. We will try to promote another conference within a year from now.

Joe Benitez: You know when I was a little boy living on the reservation walking down the dusty roads with no shoes, tattered clothes, family barely able to feed me I asked myself, what am I going to do and what am I going to be. When I got older I could see the problems arising among my own reservation and the conflicts the tribal members were encountering. When I became about 20 years old I decided to do something about it. I became tribal chairman for my own reservation.

Three years ago I started working with health, not knowing a thing about it. I was a salesman for 13 years, selling furniture and plants to people. I see a great need again in the health area. I became a health board member representing my own reservation and they hired me as a project director which is the Riverside-San Bernadino County Indian Health. I became a board representative to the CRIHB and then I became chairman of that organization. It has been a long trail for me, a dusty trail, an asphalt trail, but I think I have accomphlished for my Indian people, things that I wanted to do.

When the planning for the conference began six months ago, I thought to my self you've got one hell of a job to do and you have a short time to put it together. When the California area was picked for the conference, I was very happy to host this conference. I thought that the Indian people in California and the people throughout the United States would have a chance to look at the desert where I grew up. But you know you never can put on a conference by yourself you've always got a lot of people that are helping you in the background. Some of the people I would like to have take a bow are people who are important in making this conference go over, beginning with the 12 members of the National Indian Health Board and their alternates. Also people detailed out of IHS, persons like Jim Lawler and Gene McElyea, who is from Albuquerque. My special thanks to the CRIHB staff and some of the secretaries from the CRIHB projects. Right now I would like to take the time to applaud those who worked so hard on this conference.

I hope that you can take something back to your area that you can

discuss among your people. Mr. Chairman, that's all I have to say on behalf of the California Rural Indian Health Board. It has been my pleasure to work on the conference.

Dennis Tiepelman: At this time the conference stands adjourned until we call another conference. Thank you.

HEADING HOME: At the airport following the three-day conference were Helene Welch and Donald LaPointe, Bemidji Sub-Area representative to NIHB.

RESOLUTIONS PASSED BY PARTICIPANTS OF THE FIRST NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

RESOLUTION
OF THE
NATIONAL INDIAN HEALTH BOARD

SUPPORTING THE EASTERN BAND OF CHEROKEE INDIANS IN THEIR EFFORT TO OBTAIN FEDERAL FUNDING FOR THE CONSTRUCTION OF A NEW HOSPITAL AT CHEROKEE, NORTH CAROLINA

WHEREAS, the health delivery service extended to the members of the Eastern Band of Cherokee Indians by the Indian Health Service has for many years been inadequate, and

WHEREAS, the health, welfare and safety or members of the Eastern Band are jeopardized daily by the use of antiquated equipment and facilities, and

WHEREAS, the present structure constructed in 1936 which houses the said equipment and facilities is hazardous and incommensurable to the needs of the increasing population of the Cherokees, and

WHEREAS, planning funds in the amount of $500,000.00 have been granted to the Eastern Band of Cherokee Indians for the planning of a new hospital which will meet the criteria for accrediation, and

WHEREAS, $6,900,000.00 is needed for construction.

NOW, THEREFORE, BE IT RESOLVED THAT:

1) the National Indian Health Board hereby supports the Eastern Band of Cherokee Indians in their effort to obtain the necessary funds for the construction of a new hospital which will serve the needs of the Indian people.

HOWARD E. TOMMIE, CHAIRMAN
National Indian Health Board

RESOLUTION
OF THE
LOCAL NATIVE HEALTH CORPORATIONS

TOTAL BENEFITS FOR HIRING
PROFESSIONALS UNDER LOCAL
NATIVE HEALTH CORPORATIONS

WHEREAS, funds contracted to Alaska Native Health Corporations to maintain programs for Public Health Service/IHS are not adequate to provide salaries competitive with other Alaska business enterprises and IHS; AANHS; and;

WHEREAS, funds provided by IHS to Native Health Corporations for employee benefits are inadequate to compete with other Alaska Business Enterprises and with federal employees benefits program of PHS/IHS/Alaska Area Native Health Service, and;

WHEREAS, this condition is detrimental to the development and implementation of health delivery systems to the native people of Alaska, and;

WHEREAS, this condition is impeding the implementation of Public Law 93-638 in Alaska;

THEREFORE, BE IT RESOLVED that the National Indian Health Board shall work with Alaska Area Native Health Board in obtaining funds and regulations to provide employees of the Alaska Native Health Corporations salaries and benefits comparable to IHS, AANHS and other Business Enterprises in Alaska.

RESOLUTION
TO THE
NATIONAL INDIAN HEALTH BOARD

REQUESTING THAT THE NATIONAL INDIAN HEALTH BOARD ESTABLISH A SUBCOMMITTEE TITLED "U.S. SCHOOLS OF PUBLIC HEALTH/INDIAN HEALTH"

WHEREAS, there is an immediacy for the need to train Indian health personnel, and

WHEREAS, there is a further immediacy for the training of public health specialists to meet the great demands in sanitation, water quality and accident prevention in all Indian communities, and

WHEREAS, there is a great need to develop culturally sensitive materials and programs to meet the needs of the public health of Indians, and

WHEREAS, the United States has 19 Schools of Public Health where there are only 49 Indian students currently enrolled in only 10 of these schools, and

WHEREAS, these Schools of Public Health should assist and teach Indians to improve their quality of life

THEREFORE, BE IT RESOLVED that the National Indian Health Board establish a subcommittee titled "U.S. Schools of Public Health/ Indian Health", to address the immediate training needs on the undergraduate, graduate and post graduate levels for Indian people seeking careers in public health.

BE IT FURTHER RESOLVED that the priority task of the committee be to contact all U.S. Schools of Public Health and initiate courses, workshops and whatever other programs necessary to improve the health and well being of all Indian people.

RESOLUTION
OF THE
BETHEL SERVICE UNIT AREA

REQUESTING SOLID WASTE CONTROL SYSTEMS IN THE BETHEL SERVICE UNIT AREA

WHEREAS, adequate solid waste control is necessary in the interest of public health to prevent the widespread transmission of disease and accidental exposure to people living within the Bethel Service Unit, and;

WHEREAS, conventional means and practices of solid waste collection and disposal are not practical nor applicable in this geographic setting due to climatic, soil and other environmental considerations, and

WHEREAS, environmental conditions are deserving of attention and efforts at present, and the problem is becoming more severe with the ever increasing use of processed foodstuffs and other materials requiring disposal, and;

WHEREAS, many villages within the Bethel Service Unit have recognized the problem of solid waste control and have expressed a desire to upgrade and correct existing deficiencies;

THEREFORE, BE IT RESOLVED that the National Indian Health Board assist the people of the Bethel Service Unit to acquire assistance from appropriate governmental agencies to develop, implement and evaluate the means to control solid waste by instituting pilot projects and advancing technology and awareness to provide a more healthful environment.

RESOLUTIONS REFERRED TO

THE NATIONAL HEALTH INSURANCE

CORE GROUP

RESOLUTION
OF THE
MENDOCINO COUNTY INDIAN HEALTH BOARD, INC.

TASK FORCE COMMITTEE
NIHB/NHI

WHEREAS, the Mendocino County Indian Health Board, Inc. is recognized as one of the Health Service agencies for the Indians of Mendocino County, and

WHEREAS, the implementation of a National Health Insurance Program will have a major impact on Indian Health programs, and

WHEREAS, the Federal government has a direct responsiblity to its Indian people in the upgrading of their standard of health.

THEREFORE, the Mendocino County Indian Health Board, Inc. will not sanction a National Health Insurance Program without warranties that:

1. The National Health Insurance Program will recognize the Indian Health Service and Tribal Health programs as the major financiers and deliverers of health service to Indians and will not impose any restriction on their current delivery systems.
2. The National Health Insurance Program will supplement and not reduce funding available to the Indian Health Service.
3. Indian tribal governments must remain sovereign without State authority or jurisdiction over Indian health programs.
4. The National Health Insurance Program must not diminish the Indian's legal, historical and moral rights to health care from the Federal Government at no cost to Indian consumers.
5. The rights of the Indians living in non-reservation areas must be recognized and their rights to service protected by the National Health Insurance Program.

The foregoing resolution was passed by and carried this 25 day of June 1976, by unanimous decision by the Mendocino County Indian Health Board, Inc.

RESOLUTION
FROM THE
CHOCTAW NATION OF OKLAHOMA
HEALTH ADVISORY BOARD
FOR
A NATIONAL HEALTH INSURANCE PLAN

We believe, first, there is a definite need to provide for the special health needs of our Indians. Second, we should work with and through the IHS until the concept of Self Determination is realized or rejected. Thirdly, we must, as citizens of the United States participate in a health plan that is equitable to all United States citizens.

We, therefore, recommend the following action be taken.

I. INFLUENCE FEDERAL LEGISLATION TO:

A. Obtain specific language in legislation defining and preserving the rights of Indian people to federally-funded health care. The Snyder Act and subsequent legislation should be worded with more authority to provide obligations to Indian health care.

B. Preserve the tribal sovereignty concept in order that Indians may continue to solve Indian problems. Legislation must insure that health resources for Indians must not be administered through local or state governments and the Federal government shall not set policy for Indians.

C. Insure that the concept of Self Determination will not be jeopardized through a National Health Insurance plan. Any NHI legislation should proclaim Indian rights and Indian positions within the NHI system.

D. Preserve the Indian Health Service as a health delivery mechanism. Continue to obtain congressional appropriations and obtain NHI reimbursement to upgrade health facilities and health services.

II. INFLUENCE TRIBAL PARTICIPATION IN INDIAN HEALTH

A. The IHS must become a primary source of health care with proper funding.

B. Tribal involvement must become a reality. Tribes must be able to participate in policy formulation at every level within IHS.

C. Tribes could continue to have the option to assume responsibility for health care delivery to Indians.

III. INFLUENCE NHI PLAN

A. CONCEPT: Universal federalized comprehensive health insurance plan with provision for reorganization of health care system and development of health resources.

B. AVAILABILITY: Should cover all U.S. residents.

C. BENEFIT STRUCTURE: Should cover the entire range of personal health services with no limitations. Provisions for the poor and aged provided by the government.

D. REIMBURSEMENT: Operates on annual national budget - negotiated budget to providers. Providers barred from making additional charges to individuals.

E. QUALITY CONTROL: Should establish a quality control commission and formulate national standards. Majority of consumer representation and input required.

F. ADMINISTRATION: Should be a branch of federal government, e.g., H.E.W. Provisions for consumer representation.

G. FINANCING: 50% from general tax revenues and 50% from some formula involving employer and employee, e.g., employer 1% payroll-employee 1% after first $7,500.